the MODERN HOSPITAL

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Just in Passing—

HIGHLIGHTING our November issue will be a full report on the A.H.A. St. Louis convention. Whether you are there or are held at home by the war's emergency demands, you will find that this overall summary will give you the best available understanding of just what happened at St. Louis.

THE first of two reports on the poll on the Social Security Board's proposals as conducted by the A.C.H.A. appears in this issue. And very timely it is since Representative Eliot of Massachusetts has introduced a bill to expand widely the provisions of the Social Security Act. The previous College poll revealed that most hospital administrators want their employes to have the protection of old age benefits and a considerable number (but not a majority) want unemployment compensation also. This poll deals with the hospitalization aspects.

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The Modern Hospital

OTHO F. BALL, M.D., *President*

RAYMOND P. SLOAN, *Editor;* ALDEN B. MILLS, *Managing Editor*

MILDRED WHITCOMB, *Associate Managing Editor*

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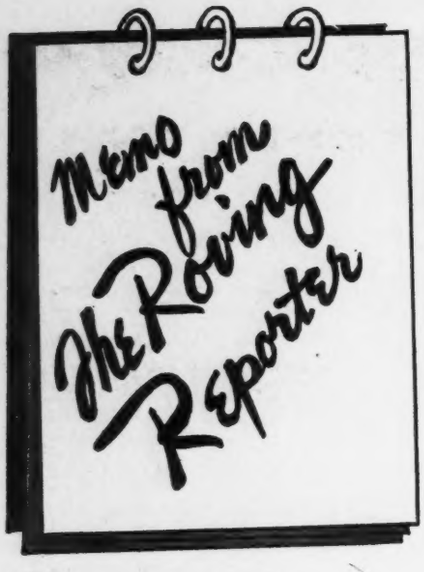

Introducing the Newcomer

So proud is Mercy Hospital, Chicago, of a new member of its housekeeping staff that a complete biography of the newcomer and a full page portrait appear in its monthly magazine.

Mercy Hospital regards the new staff member as the foremost contributor to its recently announced campaign of man-hour and material conservation.

Brought into the hospital "so that the hours needed for cleaning the halls could be cut down and thus free personnel for other jobs," Mercy's new worker "also saves soap and takes away the drudgery that formerly went with the mopping up of the blocks and blocks of hospital halls."

You've guessed it—the much heralded new maintenance helper is a floor scrubber. "The motor is equipped with a silencer so that patients will not be disturbed. The machine can be easily run by women."

Much ado about nothing? We think not. The public needs to know all of the various elements that help a hospital function in that important job of carrying on its war effort. Even machines may be given a "human interest" appeal.

● ●

Halt That Visitor!

Do visitors walk unchallenged through your hospital's back and side entrances? Do guests wander unhindered down corridors and up staircases?

There is a war on, saboteurs are about and there is no better place to start a panic or to throw a monkey wrench into the community's health machinery than in your hospital.

No unauthorized person is now admitted to the Alameda County Hospitals, Oakland, Calif., except through the main entrance. There he gives his name, his business and is admitted to see friends or officials only under the surveillance of employes.

Dr. Ben W. Black, the administrator, trains every nurse, maid, porter or other employe to stop persons seen walking in the corridors or about the institution.

"May I help you?" a maid asks courteously of the man who, upon leaving his friend in the ward, passes the bank of elevators and continues down the corridor.

"I'm looking for the housekeeper's office," the visitor may reply.

"The housekeeping department is right over here," says the maid and does not leave the visitor until she has escorted him to the proper office.

"To permit promiscuous visiting is one of the most senseless things we can do," Doctor Black declares. "Yet I can walk in a dozen hospitals without anyone challenging me."

So can all of us, Doctor, but your plan is the wise one in war time.

● ●

Aid to F.B.I.

The F.B.I., the provost marshal of Morris Field and the police department of Charlotte, N. C., appealed to the social agencies of Charlotte for aid in dealing with young local girls picked up by vice squads.

First always in taking community responsibility came Charlotte Memorial Hospital with Medical Social Worker Cochran responding as a volunteer. Three mornings in police court led Miss Cochran to take a wise step—the making of a survey of job opportunities in the city so that girls who were sincerely interested in a change of occupation might be referred.

The U. S. Employment Service enlisted in the project and the placement chairman agreed to give the girls that which most of them claim is all they need—"a decent chance."

Says Miss Cochran: "If our efforts in behalf of the 'young girls of the street' result in the rehabilitation of only one of them, they will have been more than worth while."

Now all young girls are interviewed by a social worker before they are released by the vice squad or are sent to a place of detention. It is likely that a regular social worker will be employed for the rehabilitative work if the need seems sufficient.

● ●

Hospital Halitosis

Many hospitals have a slight case of halitosis but the affection of even a devoted public is likely to cool when the elevator shaft reeks of sewage.

That was West Suburban's trouble. When the elevators rose, so sometimes did the stench at that excellent institution in Oak Park, Ill. The architect had happened to locate near the base of the elevator shaft certain sewerage sumps to which are drained dishwater and other wastes for raising by bilge pumps to the street sewer level.

Under certain atmospheric conditions, the easily imagined odor seemed to penetrate the entire shaft, particularly with the high speed, 400 feet per minute cars acting like huge syringes.

You can imagine what a headache that was to the administration. Supt. L. C. Vonder Heidt and his board lost plenty of sleep. They tried various chemical deodorizers with indifferent results. Then someone had a really brilliant idea.

Now you can step into West Suburban Hospital regardless of internal or external weather conditions and the smell is sweet and clean. You can ride the elevators with nostrils unoffended. An ultraviolet air sterilization unit has been installed at the base of the elevator shaft. It has been in use for a year now and the community has forgotten that the hospital ever had halitosis.

● ●

Patients' Press

The *Children's Hour* is a crusading newspaper. Published by the children of the pediatrics division of Bronx Hospital, New York City, its correspondents and editorial writers, whose average age is 8½ years, express their views on a variety of topics.

Take Reporter Freddie Parkel, for example. He comes forward in a recent issue with an idea an adult metropolitan editorial writer might have been glad to have sponsored. "Why can't Mother's Day and Father's Day come at the same time?" he asks.

Writes Freddie: "Sunday, June 21, 1942, was Father's Day. Although I was in the hospital, Miss Weinstein let us make cards to send to our dads on that day. My father is very good to me. He takes me on hikes, trips and buys me everything I want. I sent my mother a card, too, so she would not feel bad when only my father received one."

Contributor Martin Lasky, 7½ years old, comments on our nation at war: "We are losing many ships," he writes. "We are losing men, too. We must be ready at any time for an invasion from anyone. We must have courage at any cost to keep this freedom, democracy and liberty."

The part of this mimeographed sheet that the child patients like best is the section of conundrums, most of which were familiar to the 8 and 9 year olds of fifty years ago.

Work on the *Children's Hour* is supervised by the school teacher assigned the hospital and by the play therapist.

Supt. William B. Seltzer is enthusiastic about the children's newspaper.

Small Hospital Questions

Conducted by Gladys Brandt, R.N., Children's Free Hosiptal, Louisville, Ky.; Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William J. Donnelly, Princeton Hospital, Princeton, N. J., and others

Doctors' Telephone Calls

Question: How do hospitals charge doctors for telephone calls?—A.P., Mich.

ANSWER: The commonest procedure in charging physicians for telephone service is to set up charges on all toll calls (calls other than local calls) on charge tickets, which are submitted to the business office and billed monthly.

Hospitals differ as to whether or not they make charges for local calls. It seems to me that local calls should be allowed without charge as a courtesy to the hospital staff.—ROGER DEBUSK.

Employe Conferences

Question: How worth while are weekly or monthly employe conferences? What employes are expected to attend and what type of discussion is held?—J.L.P., La.

ANSWER: If this question refers to staff conferences with heads of departments, after several years' experience these have been given up in our institution. There are many reasons for this decision.

Employe conferences, however, are a different matter. Our graduate nurses are organized and have their own committee; the student nurses have their student council; the sub-lay staff, male and female, including laundry employes, is organized in a union and conferences are held with the union committee whenever the hospital or the employes request it.

Those who attend our employe conferences are appointed by their various groups. Discussions are on many subjects, such as unwarranted dismissals, better working conditions, increase in salaries, cost of living bonus and any suggestions that might come from the employe groups in the interests of the hospital.

Since the outbreak of war a great deal of stress has been laid on the question of economies and it is encouraging to note how satisfactorily the employes have responded to these requests.—A. K. HAYWOOD, M.D.

Free Service for Employes

Question: Is the majority of hospitals allowing free bed service to employes, or a discount on their hospital bills?—G.C., N.Y.

ANSWER: From a study I have just made of the hospitals in Minneapolis, the majority provides an opportunity for employes to join the Minnesota Hospital Service Association or some other plan that will protect them. If they do not take out such memberships, they are expected to pay their own hospital bills at full price. Only one provides free service and that is a public institution in which only free service is provided anyway. One other allows a 20 per cent discount and another gives a 50 per cent discount on the room price.

The general feeling on the part of employes seems to be that they would rather receive the full value of their services in cash and provide for themselves in their own way, as do their friends and relatives, *i.e.* by joining some Blue Cross plan.—NELLIE GORGAS.

Nurses' Salary Scale

Question: We have a salary problem. Our nurses' salary scale is $65, $70 and $75 a month, with $65 paid to nurses for first year, $70 for one year to five years, and $75 for more than five years. We feel a nurse in the employ of the hospital for more than one year is worth more than the new employe, but we are having some discussion over this scale. What is your opinion?—B.C., Iowa.

ANSWER: In general, there is little to substantiate the idea that a nurse's value to the hospital increases with years of employment. A nurse will probably reach the peak of her ability as a general duty nurse within three years after graduation.

If she has not, by that time, earned promotion, her earning ability may be considered to have leveled off until or unless she enters upon an unusual personality development which might bring to the fore special aptitudes previously dormant.

Length of service alone is not justification for increase in salary.—HAROLD K. WRIGHT.

Standard Rates for Medications

Question: What are some acceptable methods of keeping account of dressings and medications when inclusive rates are not used?—F.M.J., Fla.

ANSWER: It is important to set up standard rates for all dressings and medications. Then, as the patient receives a chargeable drug or service, the nurse carrying out the order makes up a memorandum giving the room number, hospital number, name of patient, name of doctor and the drug or treatment administered.

Each day the director of nurses transfers this information to a daily charge slip, which is then turned in to the accounting office. Charges are posted direct to the patient's ledger card and the report slip becomes the supporting accounting medium.

The daily charge report form devised by the United Hospital Fund of New York is quite acceptable and will prove a great help in the compilation of statistics.—WILLIAM J. DONNELLY.

Blackout Arrangements

Question: What preparatory steps would you advise for small hospitals in conforming with blackout regulations? What method is least expensive and most practical?—S.M.C., Ill.

ANSWER: The first steps to take would be to black out the kitchen, surgery, delivery room, chart room, laboratory, x-ray and all departments that need to be lighted during a period of emergency.

It is better to purchase some lightproof material rather than paint the windows for obvious reasons. This material can be rolled up and tied when not in use; then when it is needed it is already attached to the windows and someone needs only to pull the string and the windows are quickly blacked out.—A. A. AITA.

No Real Discrimination

Question: Do hospital service plans admit proprietary institutions to membership? If not, why not?—M.F.J., N. Y.

ANSWER: While many proprietary institutions have been admitted to membership in nonprofit hospital service plans, most Blue Cross plans have limited their hospital membership to nonprofit hospitals. This is not possible in some areas in which proprietary institutions are the only institutions available to subscribers. When a blanket exclusion against proprietary institutions has been adopted, the reason usually given is that the inclusion of proprietary hospitals might prejudice taxing authorities against the tax-free status of the Blue Cross plan.—E. A. VAN STEENWYK.

Locked Hooks for Gowns

Question: Since we have no lockers in the staff room because of lack of space, the use and distribution of gowns present a problem. Just how do locked hooks operate and would they work out satisfactorily?—E.M., N.Y.

ANSWER: We find the use of these locked hooks most satisfactory. The only disadvantage is that one must be careful not to leave anything in the pockets to invite thievery.—ALTA M. LABELLE.

LOOKING FORWARD

A Neighborly Gesture

WHILE engaged in the pursuit of our enemies all over the world, the opportunity for a neighborly gesture lies almost at our doorstep. The interview with Doctor Vargas published elsewhere in this issue reveals the great need for young Brazilian doctors to take advantage of North American hospital and university facilities for graduate work. The one obstacle to the accomplishment of this aim is a little matter of dollars and cents—twenty Brazilian dollars, to be exact, to one American dollar. The result is that with Germany and France no longer acting as hosts, these young men must remain at home and do the best they can with what they have. Yet the Brazilian government is striving conscientiously to raise its medical standards.

It would seem politic, particularly at this time, to make the necessary provisions by which groups of South American doctors might share the benefits of our modern equipment and scientific knowledge. There would be mutual benefit as well in the personal contacts thus established, marking definite progress in the trend toward international organization. It is heartening even to ponder over the privilege of being able to evince neighborly interest in a world filled with hate and horror.

Thanks to the Red Cross

IN ORGANIZING lay groups of varied interests and backgrounds into efficient working units the American Red Cross has demonstrated the power of public support under competent leadership. In hospitals, canteens, service recreation centers, camps—everywhere is evidence of keen insight in detecting needs and rare ingenuity in meeting them.

As seriously handicapped as our hospitals may be today in maintaining standards, it is not difficult to picture them in a far worse state without the assistance of Red Cross nurses' aides and Gray Ladies. More recently there have appeared on the scene Red Cross "Yellow Birds" whose functions are described as staff assistants and who are trained to inscribe information on hospital charts, take telephone messages, arrange flowers, carry food trays and assist in clinics and other departments where they may be needed. They constitute further evidence that the Red Cross is trying to visualize hospital needs and help in solving them. In return, it deserves the thanks of the entire hospital field and its utmost cooperation.

Blindspots in Program Making

TODAY we are living through a social revolution. Hospitals, like all other agencies of our society, are being stirred by various aspects of this revolution. Their whole future relations to one another, to the public and to the government will be reexamined and realigned in the postwar world. The function and place of the hospital trustee will be greatly changed.

In view of all this, it is a great disappointment to scan carefully the program of the war conference of the A.H.A. to be held in St. Louis this month and find no indication that the association is even aware of these important changes. The program for the trustees' section, for example, could have been presented five, ten or twenty years ago with equal aptness. While the speakers are outstanding, their subjects are now "old stuff" to any alert trustee.

Nor will our eager inquiring trustee or administrator find much in other sections of the program to tell him about the "shape of things to come." The program is packed with material about the war, on the assumption, perhaps, that the war is to last for many years and that there is plenty of time to think about the postwar world when the final battle has been won.

What a childlike optimism such a view reflects! If this war stretches on for three or five or seven more years, the death knell of our individualist, capitalist society may long since have been sounded. It will then be too late to discuss the future of the voluntary hospital.

While the A.H.A. coordinating committee and the association's board of trustees have been groping with the thought of setting up a national commission to study the place of the voluntary hospital in our future social organization, one would never know

from the St. Louis program that the idea had even crossed their minds. Apparently this is to be one of the "minor" unimportant activities of the association that can be discussed quietly and at leisure. But the sands in the hourglass are steadily running out. Will the A.H.A. awake in time?

What Should Nurses Do?

EVERY hospital is in a constant quandary today as to what advice to give nurses. Who should go? Who should stay?

To help hospitals and other employing agencies as well as individual nurses, the National Nursing Council for War Service has set up two categories worked out by the council's committee on supply and distribution and approved by the health and medical committee and nursing subcommittee of the Office of Defense Health and Welfare Services as well as by the American Red Cross. Free copies of the report, "Nurses to the Colors," will be mailed on request to the council, 1790 Broadway, New York City.

"You should serve with the armed forces," states the council, "if you are single, under 40 and are (1) doing private duty, (2) on a hospital's general staff, (3) a head nurse not essential for teaching or supervision, (4) a public health nurse not essential for maintaining minimum civilian health service in any given community, (5) in a nonnursing position or (6) an office nurse.

"You should serve at home, at least for the present, if you have a position (1) in a hospital that has a school of nursing as (a) an administrator in a key position, (b) an instructor, (c) a supervisor or (d) a head nurse in a position related to teaching or supervision; (2) in a hospital without a school of nursing as (a) an administrator or (b) a supervisor; (3) in a public health agency as (a) an administrator, (b) a teacher and supervisor, (c) a staff nurse essential for maintaining minimum civilian health services in any given community or (d) an industrial nurse."

The leaflet goes on to suggest that the reader analyze her town's needs. "These recommendations must be adjusted to local conditions. Nursing resources of the entire nation must be pooled to win the war; nursing resources of the entire United Nations must be pooled to win the peace."

The aim of this study is to get every nurse into the place where she is most needed. "Such reshuffling of activities should eliminate duplication of nursing services, luxury nursing and employment of nurses in nonnursing positions."

While we might feel at first glance that the advice favors public health agencies somewhat more than hospitals, we must realize that the public health nurse ordinarily serves more individual patients than the hospital nurse, that adequate home service may help to keep down overcrowding in the hospitals and that we in hospitals have more opportunity to use volunteers and subsidiary workers than have the public health organizations.

Private duty nursing in hospitals will probably soon be almost a thing of the past. There are many people who doubt whether it will ever again resume a prominent place in the hospital picture. Why shouldn't the necessary nursing service be furnished by the hospital to private patients as it is to ward patients? This will conserve nursing sources since a nurse on the general duty staff can be used more effectively than one doing private duty.

Needed—Dietitians

MUCH attention has already been focused upon the serious shortage of help in hospital kitchens. Apparently with inducements of higher wages at every turn there is little to tie unskilled labor to its pots and pans. Now an even more pressing problem impends in a threatened shortage of graduate dietitians. In recent weeks renewed pressure has been exerted by the government upon young women with approved training to assume responsibility for nutrition in government hospitals, particularly Army station hospitals in this country and overseas. At the same time opportunities in state education programs are taking a toll among hospital dietitians. Nutrition, it appears, has finally come into its own.

George St. J. Perrott, chief, division of public health methods, and Harold F. Dorn, senior economist, United States Public Health Service, found as long ago as last December a need for 550 graduate dietitians in nongovernmental and in nonfederal governmental hospitals. Of these, 204 were needed to fill positions for which funds were available and 346 were needed to fill positions which were to be created by expansion of existing facilities. Undoubtedly, since last December the situation has become much more acute. These shortages, at the time the study was made, constituted more than 10 per cent of the total number of dietitians employed.

Possible answers to the question are found in increasing the size of student groups in those hospitals offering approved training courses, in the reestablishment of courses that have been discontinued and, finally, what seems most essential under the circumstances, in the organization of new courses. The only alternative is to lower standards which, in view of new demands for scientific nutrition, is to be avoided except in the direst emergency.

Despite the fact that the American Dietetic Association has under advisement the approval of five additional hospital courses, many more will be required if the needs are to be met. It constitutes one more challenge to the already overburdened administrator, yet one that he cannot ignore, faced as he is with the inescapable fact that the majority of patients must be fed properly three times each day.

BRAZIL *Guards Its* HEALTH

An Interview With Dr. Luthero Vargas

RAYMOND P. SLOAN

"MORE has been accomplished in raising health standards in Brazil in the last ten years than during the preceding thirty years." To this significant statement Dr. Luthero Vargas, eldest son of President Getulio Vargas of Brazil, adds, "But we still have some distance to go."

To gain guidance in what direction to take, Doctor Vargas, chief surgeon of the Centro Medico Pedagogico "Oswaldo Cruz," has been visiting in this country for several months studying orthopedic methods particularly but also the architecture, construction and equipment of North American hospitals.

New York, Rochester, Minneapolis, Washington and Los Angeles are some of the points he has visited from which he has gathered ideas for the 100 bed wing he is constructing for the treatment of poor children in Mangueira, fifteen minutes from the center of Rio de Janeiro.

Only occasionally does lack of the right word halt his enthusiastic comments. "Your buildings contain the best equipment; your preoperative and postoperative care, your physical therapy are unsurpassed. And Los Angeles County Hospital!" The dark eyes of this stocky, 30 year old Brazilian flash at mere mention of the name. "What a building that is!"

Doctor Vargas, like many another young Brazilian doctor, studied in France and Germany following his graduation from medical school in Brazil, so his estimates of medical care in the United States are based on what he has seen abroad as well as in his own country. He sums it up briefly: "You have the best, but"—he smiles ruefully—"the best is expensive. It's the rate of exchange —20 Brazilian dollars for one American dollar. It makes it difficult for our young men who would study here. That's why so many of us went to France and Germany. Perhaps one day that will be changed."

The interview took place as news of President Vargas' declaration of war with the Axis was coming over the wires. A few weeks previous Doctor Vargas had expressed the hope that he might stay in this country longer to do some postgraduate work. Reference to his original intention produced no look of keen anticipation now. His usually jovial face was set in hard, determined lines. "I shall be returning soon," he stated without further comment.

The new orthopedic wing of the Institution Centro Medico for which Doctor Vargas is responsible is the realization of a dream. There are 120,000 school children in Rio and only 200 beds in the city's children's hospitals. Private hospitals take care of noncharity patients.

Those who are familiar with the policies of the Brazilian government know that its first interest is the people, and they will recognize in the absorbing interest of its president's son in crippled children the beliefs expressed some time ago by the famous father: "I believe that this desire to improve the race, to give our country strong and healthful people will find expression in all departments of national activity."

No effort has been spared in this latest addition to hospital facilities in Rio to provide the best possible orthopedic care for children from 5 to 16 years. One of the greatest problems was the proper orientation of the building. Unlike this country, southern exposure in Brazil implies not sun, but cold and driving rains at certain seasons. Northern exposure, on the other hand, means relentless heat during summer, which is from October to April. For months Doctor Vargas studied how to place the building so that its wards would receive sufficient sun during the winter, yet be assured adequate protection at other times. He is particularly proud of his achievement and hopes that the building with its therapeutic pool, its dispensary, its provisions for surgical, clinical and heat treatments, also for nose and throat surgery, may prove a model for other cities.

The new wing to Institution Centro Medico is constructed of concrete, a material well suited to local climatic conditions. Its design is modern. It was surprising to Doctor Vargas when first he came to the States to discover how infrequently modern design is used here. Brazilian hospitals, because of the comparative cheapness of the land, spread out into landscaped gardens with patios and terraces.

He describes with pride the long verandas he has provided from which his young patients can enjoy an unobstructed view of the sea. "And think of it," he adds, "free splints, braces and other equipment will be supplied out of the city's funds for the poor."

HOSPITAL DE CLINICAS, SAO PAULO

Photos, Silva Jr.

Doctor Vargas has the mind of the idealist in the robust body of a cowpuncher, for like his father and his grandfather before him he was reared on a ranch in southern Brazil. Seated across the table in the crowded dining room on a New York hotel roof, he looks straight at you and beyond—beyond New York's skyline, across tremendous seas of grass whose billowy surfaces are interrupted only by occasional "umbu" trees—Brazil's famous "Purple Lands." Enthusiastically, he tells of what has been done to improve the health of his people, of what remains to be done and of what is needed, for Brazil is a vast country and its living standards are low.

The government is the people's teacher, he explains. Working in cooperation with industrial plants, it is orienting the worker to the health program. Agencies, such as the Labor Syndicate, the ministries of education and public health, each and all play an important part. Cafeterias are provided for the workers where for 6 cents they can get a balanced meal. In addition, while eating they read posters and bulletins and listen to radio talks describing the importance of proper foods and the use of balanced diets, that is, more milk and eggs.

"For Brazilians do not eat enough milk and eggs," Doctor Vargas adds. "They are meat eaters principally. They also consume far too much flour, beans and starchy foods. Yet surprisingly enough, the general health, in Rio at least, is good."

The Brazilian physician laughs as he attempts to describe the difficulties in getting workers to carry their own trays in the cafeterias. "Unlike you North Americans, the Brazilian has had little experience with cafeterias. Such a thing was practically unknown until introduced by the government. Now the attitude is gradually changing in favor of cafeteria style. He likes it, too."

Public departments not only have modern cafeterias but they operate clinics, emergency rooms and dentists' offices in which care is provided at no expense to the employe. Each department, too, has a social service worker.

Its children, however, are of greatest concern to the Brazilian government for, as Doctor Vargas puts it, "a repeating boy is a sick boy. It is cheaper for the government to pay the expenses of a boy's treatment than to pay his teacher to carry him another year."

Consequently, the health department plays a major rôle in child welfare. It provides prenatal and postnatal care and follows the child's progress closely up to five years. At that point and until he reaches the age of 17 he becomes the responsibility of the Department of Education. Vaccination for diphtheria and measles is compulsory until the age of 4 and nutrition is being given increasing attention by trained people. Rio distributes free milk to school children.

"All of this," says Doctor Vargas, "has had a definite effect upon infant mortality, which has decreased appreciably during recent years. Tuberculosis is still prevalent, but infantile paralysis is infrequent in Rio,

SANATORIO ESPERANCA, SAO PAULO

LUNCH TIME IN A RIO DE JANEIRO WORKERS' CAFETERIA

and never in epidemic form." Why this should be so he finds it difficult to explain for "polio" is generally considered a summer disease and in Rio it is eternally summer.

It was inevitable that the conversation should finally get around to health insurance, for since 1923 Brazil has provided both medical and hospital care for its wage earners. Briefly, the plan is this. Members, employers and the government each contribute one third of the total fee, which amounts to about 50 cents a month. This covers the individual, his wife and family. Even in the event of his death, the employe's family still retains the privileges. Between two and three million are enrolled, according to late figures.

The plan does not apply to professional people, however. Doctor Vargas chuckles: "You see in our country it is the poor people that, what you call it, 'get the breaks.'"

The best hospitals in Rio, in fact, are public institutions. These include, in addition to general hospitals, special sanitariums for tuberculosis and mental diseases. Those who can afford to pay are accommodated in private hospitals or hospitals run by religious orders. It has been the custom to operate special emergency hospitals or stations from which the patient is moved to other institutions as his condition, both physical and financial, seems to warrant.

And now for the question: "What is the greatest need of Brazilian hospitals and how can the United States help?"

Doctor Vargas answers without the slightest bit of hesitation:

MINISTRY OF EDUCATION AND HEALTH, RIO DE JANEIRO

"First, better nursing. Although higher standards for both doctors and nurses have been established in recent years the supply is inadequate. Brazilian girls are not attracted to nursing. Remuneration is low and the profession is not highly regarded socially. For this reason much of the nursing care is rendered by maids or by interns. We are hoping that the splendid work being done by public-spirited women who for some time have been volunteering to make beds, take temperatures and give general bedside care will change the feeling that has existed.

"Another problem has to do with our young doctors. Where are they to go for graduate work if not to the States? Everything is here that they need—but what are they to use for money? Twenty to one; it's hard.

"We also have need of your modern equipment and supplies. Brazilian hospital people want to learn, they want to follow what's new, and particularly they want what North America has to offer. It is for this reason that literature on the subject, such as is contained in *El Libro del Hospital Moderno,* has been so widely read and consulted. You see, we have need of all such help you can give us."

Although the last three years have witnessed Brazil's greatest progress in its hospital and health program, the work has been going on longer than that. Only recently news dispatches carried the death of an illustrious Brazilian, Pedro Ernesto Baptista, surgeon, who was mayor of Rio during the Vargas regime and who labored to improve conditions in Rio's slums by building clinics and city hospitals. Today a bust of him who was ever the "people's man" stands in the city hall.

Possibly it is of Baptista, perhaps also of that other "people's man," his own illustrious father, Getulio Vargas, that the young doctor thinks as he gazes thoughtfully over New York City's skyline. Suddenly he smiles broadly.

"And you want to know one other thing we lack? We have no Sister Kenny—a wonderful woman that. Yes, I saw her work in Minneapolis. But that may happen, too, who can tell? In the meanwhile. . . . "

He was interrupted by a voice over the radio: "Vargas has this day declared war on the Axis powers."

If Your Personnel Needs a Lift

MOTION and TIME studies are in order

LT. WILBUR C. McLIN

U. S. ARMY MEDICAL CORPS
FORT RILEY, KAN.

"THERE is no waste of any kind that equals the waste from needless, ill-directed and ineffective motions with the resulting unnecessary fatigue. Because this is true, there is no industrial opportunity that offers a richer return than the transformation of ill-directed and ineffective motion into effective activity."[1] So said Frank B. Gilbreth, the initiator of motion and time studies in the field of industrial engineering.

In industry, the motion and time engineer has done much to lower production costs by the elimination of ineffective motions. A hospital, however, has a much more vital objective than industry inasmuch as the financial balance of a hospital is secondary and incidental to the balance sheet of achievement.

Now that civilian hospitals are sharing doctors, nurses and technicians with the nation's armed forces, it is becoming increasingly difficult to maintain a high standard of service. This makes ineffective motions extremely expensive in terms much more significant than dollars and cents. Several motion and time studies have been made in industrial fields that have analogous activities in the hospital, *i.e.* the laundry, the business office and housekeeping and dietary departments.

It is unthinkable even to consider the possibilities of applying time and motion studies to the methods of direct patient care, since fundamentally it is the function of hospitals to provide humanitarian and kindly care of the patient. Motion and time studies in the hospital, however, can increase the effectiveness of nurses and other personnel charged with direct patient care by eliminating unnecessary steps. This can be accomplished by a process flow chart to determine the best location of service rooms and nurses' stations and the location of the equipment in these rooms so that it is conducive to motion economy.

An example of this functional arrangement can be seen in the plans for the new Broadlawns Hospital of Des Moines, Ia., which provides subservice rooms. This point has a counterpart in conserving the time and steps of the patient, particularly in the out-patient department, which should be arranged so that even new patients can easily locate the various clinics. Administrators planning a new building or the renovation of an old plant could use this method to check a proposed layout and show possibilities for better arrangement.

Motion and time studies also increase efficiency and thereby lower operating costs in the subsidiary departments that are mechanical in nature, such as the laundry, dietary and housekeeping departments. This is especially apropos since it is coming more and more to be recognized by hospital administrators that employes in these departments should be paid a wage comparable to that paid by industry for similar work. Conversely, the hospital worker should be expected to be as efficient and productive as the employe of an industrial concern. This is accomplished by the study of individual jobs or processes with the view of improving that particular function by redesigning or changing the location of the equipment or tools used by the worker and by teaching the individual employe the art of motion economy.

To present the technical principles of this science most clearly and briefly, we quote Dr. Ralph M. Barnes, professor of industrial engineering at the State University of Iowa.[2] Doctor Barnes is recognized as an outstanding authority in this field. Necessarily, this exposition is based on the work done in industry; however, examples will be cited that will translate this science of motion economy into comparable hospital functions.

A motion and time study begins with the process flow chart. This is a device for visualizing, in a compact manner, a process as a means of improving it. In a manufacturing plant the chart begins with the raw material as it comes into the plant and follows each step of its transformation into a finished product. To portray the process, the industrial engineer has developed the following code or set of symbols:

A large circle denotes that a particular fabricating operation is being performed.

A small circle denotes the transportation of the article.

A square denotes inspection of the article either as to quality or quantity or both.

A double triangle denotes temporary storage; that is, the article is waiting for the next process.

A single triangle denotes permanent storage; that is, storing the finished product.

These same symbols could be adapted to the study of the departments of the hospital that are mechanical in nature. Special definition of these symbols of the process flow

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Mr. McLin was formerly administrative assistant at the University of Iowa Hospitals. While he is now serving as an officer in the medical administrative corps of the United States Army, the material for this article was gathered when he was in a civilian status and does not in any way involve the War Department or the Army.

[1]Quoted in Morgensen, Allen H.: How to Set Up a Program for Motion Economy, Factory Management and Maintenance Plant Operation Library, Factory Management and Maintenance, 330 West 42nd St., New York City.

[2]Barnes, Ralph M.: Motion and Time Study (second edition), John Wiley and Sons, Inc.

chart show the purpose of checking the efficiency of the proposed layout of the patient occupancy sections and clinics of the hospital as follows:

A large circle—a clinic or treatment room.

A small circle—lines of patient traffic.

A square—an administrative contact, such as an out-patient paying for x-ray.

A double triangle—a waiting room.

A single triangle—patient's room or ward.

The process flow chart presents a graphic picture of the process of being examined. If it is studied carefully many improvements can be visualized. For instance, it may be discovered that a particular step can be eliminated or combined with another process or job. To be of greatest value the process flow chart should be scrutinized with a questioning attitude.

The next principle of motion and time study is the science of rhythmic motions and motion economy as related to the use of the human body. These principles are: (1) the two hands should begin as well as complete their motions at the same instant; (2) the two hands should not be idle at the same instant except during rest periods, and (3) motions of the arms should be made in opposite and symmetrical directions instead of in the same direction and should be made simultaneously.[2]

Axioms of motion economy are as follows:

1. "Momentum should be employed to assist the worker whenever possible, and it should be reduced to a minimum if it must be overcome by muscular effort."

2. "Continuous curved motions are preferable to straight line motions involving sudden sharp changes in direction."

3. "Ballistic movements are faster, easier and more accurate than restricted (fixation) or 'controlled' movements."

4. "Rhythm is essential to the smooth and automatic performance of an operation; the work should be arranged to permit an easy and natural rhythm wherever possible."[2]

Principles of motion economy as related to the work place are:

1. "Definite and fixed stations should be provided for all tools and materials."

2. "Tools, materials and controls should be located around the work place and as close in front of the worker as possible."[2]

"Frequently the work place, such as a bench, machine, desk or table, is laid out with tools and materials in straight lines. This is incorrect, for a person naturally works in areas bounded by lines which are arcs and circles."[2]

This exposition of the science of motion and time studies is elementary. It is intended only to portray the rudiments of this science, so that its potentialities of application in the hospital can be appreciated. For detailed information we recommend Doctor Barnes' book on this subject. The second edition is preferable.

As a result of a motion and time study made at the University of Iowa laundry, labor costs have been decreased by 9 per cent, even though the number of pounds of laundry handled per year has increased 16 per cent since the study was initiated.

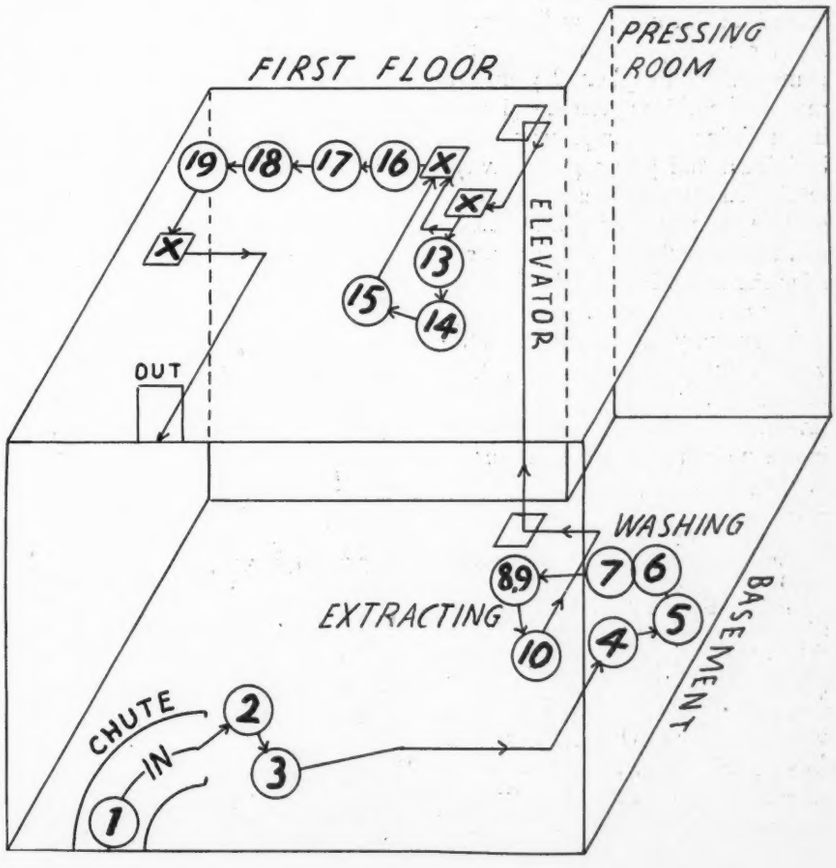
The September 1938 issue of the *American Journal of Surgery* presents an article entitled "Rhythmetic Surgery" by Doctors W. H. Lawrence and C. H. Berry, which is a commendable and convincing piece of research in the application of the principles of motion and time study in the operating room. They answer the question, "What can motion study do for surgery?" as follows:

1. "Standardize. Motion study furnishes a way to standardize surgical operations and makes possible the transference of manual skill from the expert to the beginner. . . ."

2. "Improve methods. Motion study can improve the methods of every man who calls himself a surgeon. . . ."

3. "Time saving. Motion study reduces sharply the length of time required to do the operation. . . ."

4. "Reduction of fatigue. Motion study is abundantly worth while



Floor plan of the University of Iowa laundry showing flow of bulk goods as follows: 1—unload sack from delivery truck, slide down chute; 2—weigh and record; 3—load on truck; 4—load into washer; 5—wash, rinse, blue and sour; 6—unload into extractor baskets; 7—hoist and balance load; 8—lower into extractor and extract water; 9—remove baskets by hoist; 10—move truck to elevator basket; 11—elevate to main floor; 12—wait; 13—load into tumbler; 14—close door; tumble clothes; 15—unload into trucks; wait; 16—sort, shake out and lay on racks; 17—feed into ironer and folder; 18—finish fold and stack; 19—load into basket, move to loading platform, wait for delivery to departments.

when it reduces the fatigue factor of the surgeons and nurses. . . ."[3]

While this type of study is purely in the province of the surgeon, it is cited to illustrate the universal value of motion and time studies.

In a study conducted by Lawrence A. Flagler, it was found that by applying the principles of motion economy to floor scrubbing each janitor's production was increased from slightly less than 1000 square feet per hour to 2000 square feet per hour. However, this increase was as much the result of providing proper equipment, much of it especially designed, as it was teaching the workmen the best way to do the job.[4] This is a good example of what could be accomplished in the housekeeping department.

We found one enthusiastic devotee of motion and time studies in a field that shares many problems with hospitals—the hotel industry. Herbert E. Stats, manager of Hotel Lowry, St. Paul, adopted a program of utilizing the technics of the industrial engineer. This program was originally intended to be limited to studying the plant layout for the purpose of improving space utilization and handling of materials. However, the program proved to be so successful that the scope of the work was extended to include a well-rounded, small scale application of scientific management in plant layout and material handling; personnel, including training and improvement on individual and group productivity;[5] service functions, including cost accounting, analysis of printed forms and maintenance policies, and use of scientific administration in the overall organization setup.[6]

A summary of the results of the work requires many charts; however, the fact that they were able to save more than $6000 on dishwashing alone is indicative of the success of their methods.

Several organizations have reaped the benefits of greater efficiency in their business offices as a result of motion and time studies. The most startling results are reported by one of the agencies of the federal government where the production in the filing department of the central office increased more than 800 per cent. A manufacturer of wax products reports that through the use of especially designed office desks and by arranging office layout so that the work flows in a straight line through the various departments, production was increased 15 per cent in each division of the office with some departments doing 25 per cent more work.

A well-known manufacturer of chemicals found that the production by typists could be increased 35 per cent by using an especially designed desk that exemplified the principles of motion economy, an electric typewriter with simplified keyboard and snap-out printed forms with single use carbons.

In addition to the benefits that directly accrue from a motion economy program, many other short cuts are readily apparent when employes become "time-saving" conscious. To illustrate this we again cite work done at the University of Iowa Hospitals and laundry. Prior to the tenure of L. A. Bradley, present laundry manager, who is motion economy minded, it was the practice of the laundry employes to fold the hospital linen as they saw fit. This meant that a great many pieces had to be refolded by the hospital nursing staff. Through the cooperation of the laundry and nursing service department it was discovered that it was just as easy for the laundry to fold bed sheets and draw sheets correctly, with the result that more of the time of the nursing service could be devoted to direct patient care.

As suggested by Albert H. Scheidt, administrator, Miami Valley Hospital, Dayton, Ohio, a motion economy conscious hospital executive readily recognizes the value of many commercial time-saving devices, such as a communication system between patient rooms and nurses' stations.

[3]Lawrence, W. H., and Berry, C. H.: Rhythmic Surgery, Am. J. Surg. (September 1938), New Series, Vol. XII, No. 3.

[4]Flagler, Lawrence A.: Motion Study Applied to Factory Clean Up, Abstract of Papers Presented at the Management Conference, University of Iowa, March 31, 1939, Ext. Bull. 458, p. 9.

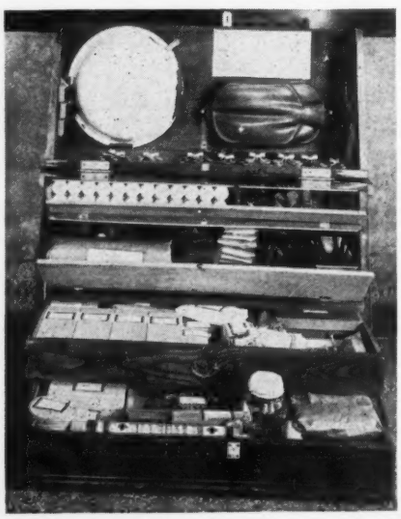
[5]Stats, H. E.: Personnel Relations in Hotel Management, J. Soc. Ad. Man. 2: 101 (July) 1937.

[6]Stats, H. E.: Evolution of an Organization Plan, Proceedings of the Minnesota Hotel Association, 1938.

Mobile Unit for Emergencies

J. H. BLAHA
GRAND VIEW HOSPITAL, IRONWOOD, MICH.

WHEN our community was organized for emergencies, it was found, because of the many large unprotected areas, that casualty or first-aid stations could not be placed in all districts. In order to assure these remote regions of adequate emergency supplies in case of disaster, we included in our emergency setup the mobile emergency unit shown below.



This unit is a 20 by 20 by 36 inch chest in which are packed the recommended emergency materials and supplies. The kit has two drawers, two shelves and a back piece. All the equipment included is listed and from this listing the doctor and his staff in the field can easily ascertain what materials are available and where they are situated in the mobile unit.

In our setup, this mobile unit can be requisitioned by telephone from any casualty station, first-aid post or remote district and, when so requisitioned, the unit is dispatched in any available car to the point of disaster. Stretchers, blankets and splints as may be required by the field group are carried to the emergency area by the same car.

A little discretion will SAVE your RUBBER

NO DOUBT thousands of pounds of rubber have gone into scrap heaps during recent years to be either burned or destroyed because America's housewives, hospital staffs and, in fact, persons in every phase of industrial and professional activity were not careful to get the longest possible service from the rubber goods they used. It has often been said: "Surgical rubber goods do not wear out, they perish or are destroyed through mistreatment."

To handle rubber goods properly means only to use good judgment. A piece of rubber is only as strong as its weakest point. A pin prick or minute snag from a sharp instrument or finger nail will often render a rubber article useless. Many of these accidents cannot be avoided in the operating room but, in handling rubber goods before and after use, they can be avoided by care.

When drawing on a surgeons' rubber glove, be careful that the finger nails of the hand holding the glove do not come into immediate contact with the rubber while it is stretched or under tension. When stretched, thin rubber is particularly susceptible to cutting by the finger nails.

When using a water bottle, the water should not be heated to more than 140° F. Water at the boiling point not only is a source of danger to the patient but ages the rubber prematurely. If the bottle is filled to the neck, the walls will bulge and permanently set if allowed to remain in that condition for any length of time. A water bottle should be filled about two thirds full with hot water. Before the stopper is inserted, the bottle should be laid on its side and the excess air expelled to prevent unnecessary inflation.

When using an ice cap or a throat collar, finely chopped ice should be used. Large pieces of ice cause discomfort to the patient and do not have the cooling effect of finely chopped ice. No attempt should be made to break the ice after it has been placed in the rubber ice cap or throat collar as such an attempt is likely to cut the rubber walls.

It should be remembered that rubber is an organic material of vegetable origin and that sunlight, heat, oils, greases and solvents are its natural enemies. If oily dressings are to be used, the rubber article should be sufficiently covered to prevent it from coming into direct contact with the dressing. Whenever contact with oils, greases or solvents cannot be avoided, the rubber article should be thoroughly washed with soap and warm water immediately after use.

When storing rubber goods after use, they should never be folded or crushed out of shape but should be laid out flat and permitted to assume their natural position. Storage of rubber goods while twisted or stretched will break down their elasticity and destroy strength at distorted points. Capacity to stretch and return to its original shape is one of the valuable properties of rubber.

The best place to store rubber goods is an unheated room where the temperature does not drop as low as freezing. It should also be a dry room. Goods should be kept in their boxes until needed.

The ultraviolet rays of the sun have a damaging effect on rubber. They quickly penetrate the surface causing the rubber to oxidize. Indirect sunlight will cause the same deterioration in time. The colors of rubber goods are also affected by sunlight.

Rubber, being an organic chemical compound, is also affected by heat. Sixty minutes in air at 360° F. will render a water bottle unfit for service. Care should be used in seeing that rubber goods, when not in use, are kept in a cool place. They should never be left in the sterilizer.

Only the rubber goods necessary to meet emergencies and serve everyday needs should be carried in the sterilizing room. Reserve supplies should be carried in the rubber goods storage rooms away from heat, light and moisture.

No matter what technic of steam sterilization is used, the most important thing is to be careful that all air is eliminated from the autoclave during sterilization. Even 0.1 per cent of air remaining in the steam chamber will double the rate of deterioration of gloves.

The higher the temperature used during sterilization the greater the degree of deterioration. Even the most resistant of pathogenic spores are destroyed by steam in a very short time at 10 pounds' pressure (240° F.). The recommendation of the U. S. government, based on experiments and tests of manufacturers' products, is 15 pounds (250° F.) for twenty minutes, which provides a thorough sterilizing without seriously affecting the gloves. Care should be taken that the actual temperature in the autoclave does not exceed 250° F. or that time in the sterilizer does not exceed twenty minutes maximum, as excessive temperature or time shortens the life of gloves.

During the sterilizing process gloves should not come into actual contact with metal of any kind. The use of talc to prevent parts sticking together is recommended as talc does not absorb the moisture and after sterilization is dry and does not affect the gloves. Starch should not be used.

A rest of twelve hours between sterilization and use is recommended. This will prolong the life of gloves and ensure better service.

Although the universal practice when using rubber goods, such as water bottles, ice caps, throat collars and invalid cushions, is to cover them with a wrapper when applying to the patient's body, it is recommended that these items be cleansed with a detergent of alcohol before sterilization. An advised method of cleansing them is to wash them thoroughly in a 2 per cent solution of cresol or plenty of soap and water.

It is perfectly safe to sterilize these items in boiling water, allowing them to drain so that no water remains inside when stored away. Naturally, repeated sterilization even under recommended conditions will cause these rubber articles to age prematurely.

A.C.H.A. Poll Reveals

Opinion Split on SOCIAL SECURITY PROPOSAL

ALDEN B. MILLS and DEAN CONLEY
MANAGING EDITOR, THE MODERN HOSPITAL, AND EXECUTIVE SECRETARY, A.C.H.A.

IN ACCORDANCE with the A.C.H.A.'s policy of ascertaining from time to time the present opinion of its members and fellows and of stimulating them to thoughtful consideration and study of important current hospital problems, a poll of opinion was conducted by the college this past summer on the hospitalization proposals of the Social Security Board. The questionnaire was formulated by the committee on poll of current issues,* with the advice of the executive committee, and results were tabulated by the college's headquarters staff.

In order to make the poll truly educational in function and to give proper foundation for the replies, a summary of the Social Security Board's proposals was included (this had been prepared by the director of the commission on hospital service). Also a bibliography was provided of the leading articles in hospital journals expressing various points of view on the subject. Each recipient was asked to study the proposal and to read the articles carefully before replying.

Even so, four of the 754 persons to whom the questionnaire was sent returned it with the statement that they did not consider themselves sufficiently informed to answer it. Three hundred filled out the questionnaire in sufficient detail to be tabulated. In addition, 145 gave supplementary statements expressing their views in greater detail than could be indicated by mere checking of "yes" or "no" after the questions. Thus the over-all return on the questionnaires was approximately 40 per cent.

The questions posed were as follows:

1. Do you think that federal financial assistance in some form is necessary if voluntary hospitals are to continue their present leadership? If so, what form of federal financial assistance would be most equitable?

2. If government (local, state and federal) would make adequate provision for the hospital care of the indigent out of general tax funds, could voluntary or community hospitals, with the cooperation of labor and industrial management, provide adequate care for all or nearly all of the great mass of regularly employed workers and their dependents by means of or with the aid of voluntary contributory Blue Cross plans in all areas of the country?

3. Would you favor legislation by which the federal Old Age and Survivors' Insurance system would be extended to provide hospitalization payments?

4. If there is to be social insurance legislation to give workers (who come under the Old Age and Survivors' Insurance system) and their dependents some insurance for hospital costs, would you favor (a) legislation by which hospitals or hospital service (Blue Cross) plans would receive a per diem payment as a cash indemnity toward the cost of hospital service rendered such persons, or (b) legislation by which the insurance system would pay a fixed sum direct to the beneficiary as a partial cash indemnity toward the cost of his hospital care?

5. Do you think the whole subject should be carefully explored by hospital representatives and the Social Security Board?

6. What practicable measures (other than hospitalization payments under the federal Old Age and Survivors' Insurance system) would you suggest as a means of strengthening the American voluntary hospitals?

It was realized by the committee that it is difficult if not impossible to formulate a set of questions that would be entirely free from any bias and crystal clear to all the persons asked to reply. Certainly, the committee was under no illusions that this set of questions achieved such perfection.

Some of the recipients of the questionnaire, for example, criticized question 2 as being too "iffy," *i.e.* as postulating conditions that are unlikely to be achieved. There is also a probability that the phrase "Old Age and Survivors' Insurance system" in question 3 was not correctly interpreted by some of those who replied to it.

The results of the statistical tabulation of answers appear in the accompanying table. The answers of fellows and members were originally tabulated separately but since no significant differences appeared between the two groups the answers have been merged.

Forty per cent of those replying to question 1 believe that federal financial assistance in some form is necessary if voluntary hospitals are to continue their present leadership. Considering only the answers of those in voluntary hospitals, the percentage remains the same.

It is interesting to compare these answers with the answers to question 2. If all of the various conditions postulated in question 2 should be fulfilled, only 7 per cent believe that voluntary hospitals would be unable to provide adequate care for

*The committee now consists of E. M. Bluestone, M.D., and Alden B. Mills.

Although sharply divided on the basic principle of the Social Security Board's hospitalization proposals, 96 per cent of these administrators favor careful joint study of the whole question

nearly all employed workers and their families when they are in need of hospitalization.

Because there is a probability that question 3 was misunderstood by some of those replying, it is necessary to be careful in concluding that there is a clear preponderance of opinion in favor of the Social Security Board's proposals.

Some respondents indicated by their comments that they thought the question referred to the extension of hospitalization payments by the Social Security Board or by state or local authorities merely on behalf of the aged or those persons who are now receiving survivors' insurance payments. Actually, of course, this question means: "Do you favor the adoption of the basic principle of the Social Security Board's proposals?"

In order to determine, insofar as it was possible, the extent of this misunderstanding all of the replies were restudied. Of those answering "yes" to question 3, four were found in which comments or remarks clearly indicated that the members did not favor the general principle of the Social Security Board's proposal. Furthermore, the answers to questions 1 and 3 were compared. It was found that 81 persons answered "no" to question 1 on the need for some form of federal financial assistance and answered "yes" to question 3. While there is not a clear-cut inconsistency in these 81 answers, yet there is considerable doubt if the persons who do not think federal financial assistance is necessary would be likely to favor the Social Security Board's proposals. This leaves a net of 71 persons who are in favor of the principle of the Social Security Board's proposals. Some of these qualified their answers by the condition that the payments should be adequate.

Among those who voted "no" to question 3, there was one who misunderstood the question and apparently thought this referred only to the aged. There were 34 who voted "yes" to question 1 but voted "no" to question 3 and there were 94 who voted "no" to both questions.

There is, apparently, enough difference of opinion among the hospital administrators who replied so that the hospital representatives appearing in Washington and elsewhere should be cautious in stating that "the hospital field agrees to this or that proposal." The replies represent largely the views of administrators in voluntary hospitals, since few members of the A.C.H.A. replying are located in governmental institutions.

If there is to be a hospitalization plan under the Social Security Board, there is a clear preference (nearly 80 per cent) in favor of payments to hospitals or Blue Cross plans rather than payments to the individual patient.

Nearly everyone (96 per cent) favors careful exploration of the whole subject by hospital representatives working in collaboration with the Social Security Board.

The supplementary statements sent in by many hospital administrators indicate that they have given careful and extensive thought to the question and have important ideas to advance. Some of the statements are so extensive that it will be impossible to quote all of them in full. Representative quotations will appear in part II of this report, to be published next month.

Opinions of Hospital Administrators on Federal Aid and Social Security Proposals

Type of Hospital	*1. Is Federal Aid Needed?*		*2. Are Blue Cross Plans, etc., Sufficient?*		*3. Do You Favor Social Security Proposals?*		*4a. Do You Prefer Payment to Hospitals?*		*5. Do You Favor Careful Study?*		*6. Number Suggesting Other Measures*	*Supplementary Statements Provided**	
	Yes	*No*	*Yes*	*No*	*Yes*	*No*	*Yes*	*No*	*Yes*	*No*		*Yes*	*No*
VOLUNTARY													
General	85	127	189	14	112	92	170	33	204	7	89	55	49
Special	11	11	16	3	9	11	17	5	20	2	10	8	5
PROPRIETARY													
General	3	7	10	...	3	8	5	6	10	...	3	1	2
Special	...	1	2	...	2	1	1	1	2	...	1	...	1
GOVERNMENT													
General	15	24	39	...	29	12	35	4	36	1	12	10	7
Special	0	2	3	...	1	2	3	...	3	...	....	...	...
Not Now Affiliated With Hospitals	5	8	12	2	9	5	10	4	14	1	7	4	3
TOTAL	119	180	271	19	165	131	241	53	289	11	122	78	67

*The number of supplementary statements were tabulated separately for those who answered "yes" and those who answered "no" to the first question.

Convention in War Time

Here is a section that will help you plan your week in St. Louis

WHAT TO SEE OF ST. LOUIS

POINT OF INTEREST	LOCATION	SPECIAL FEATURES
Art Museum	Forest Park	Visiting Hours: Monday, 2:30 to 9:30 p.m.; other days, 10 a.m. to 5 p.m.
Cathedral, Christ Church	Locust St. at 13th	Episcopal
Cathedral, New	Newstead Ave. & Lindell Blvd.	
Cathedral, Old	Walnut St. between 2d and 3d	Site of first mass celebrated in St. Louis in 1764
Concordia Theological Seminary	Wydown Blvd.	Lutheran. Beautiful campus and buildings
Eugene Field House	634 South Broadway	Boyhood home of "Children's Poet." Admission free
Jewel Box	Forest Park	Botanical exhibit of rare beauty housed in modernistic building
Lambert Field	St. Louis Municipal Airport	Some 50,000 landings and take-offs a month
Markets, Old	Soulard at 9th and Carroll Union at 700 North 6th	Reminiscent of old French markets of New Orleans
Masonic Temple	Lindell Blvd. at Spring	New mural depicting history of Free Masonry
Merchants' Exchange	3d St. from Chestnut to Pine	Largest grain exchange trading floor in the United States
Milles Fountain, "The Meeting of the Waters"	Aloe Plaza	Symbolic group of statuary by one of greatest living sculptors
Mississippi River Show Boat	Foot of Locust St.	Heart rending "meller-drammer" nightly
Old Rock House	On river front at Chestnut St.	St. Louis' first building
Neighborhood Gardens	7th, 8th, Biddle and O'Fallon Sts.	Housing project of modern European type
Post Office Bldg.	18th and Market Sts.	Murals
Shaw's Garden	Shaw Blvd.	World famous for chrysanthemums and orchids; also tropical water lilies. Admission free.
St. Louis University	Grand and West Pine Blvds.	Jesuit institution; first university in the West; medical school
St. Mark's Episcopal Church		Handsome modern structure designed by Nagel and Dunn
Washington University	Forsythe and Skinker Blvds.	Beautiful campus; medical school
Zoo	Forest Park	One of world's finest. Wild animal training shows daily. Admission free

WHAT TO SEE IN ST. LOUIS HOSPITALS

HOSPITAL	LOCATION	ADMINISTRATOR	SPECIAL FEATURES
BARNES	600 South Kingshighway	Dr. F. R. Bradley	Clinical laboratories Remodeled pharmacy
CHRISTIAN	4411 Newstead Ave.	Agnes Heman	New resuscitator and inhalator Newly equipped and modernized x-ray and laboratory departments Apartment building for nurses' home (made possible remodeling of nurses' quarters for patients, adding to hospital's bed capacity)
DE PAUL	2415 North Kingshighway		Dietary tray service Unique birthday tray service
EVANGELICAL DEACONESS	6150 Oakland Ave.	Rev. Paul R. Zwilling	New nurses' residence

HOSPITAL	LOCATION	ADMINISTRATOR	SPECIAL FEATURES
FIRMIN DESLOGE	1325 South Grand Blvd.	Sister M. Athanasia	Out-patient department Laboratory Medical social service department Gothic chapel Record system Nervous and mental diagnostic clinic
HOMER G. PHILLIPS	2601 North Whittier St.	Dr. William H. Sinkler	X-ray department Laboratory, including blood bank system Operating rooms Physical therapy department Fracture service
JEWISH	216 South Kingshighway	Florence King	Storeroom control that truly controls Dietary service: kosher kitchens; selective menus for patients in private and two-bed rooms Murals in pediatric department Demonstration of low-cost laboratory work and research in a medium sized hospital
LUTHERAN	2646 Potomac St.	Rev. E. C. Hofius	X-ray department Spectrophotometer in laboratory
MISSOURI BAPTIST	919 North Taylor Ave.	E. E. King	Homemade plaster machine in use for thirteen years without a penny's upkeep Physical therapy department Autonomous orthopedic department complete with x-ray department, sterilizing equipment, examining and operating rooms
PEOPLE'S	3447 Pine Boulevard	Ethel M. Frazier	Well-equipped laboratory New obstetrical delivery room
ROBERT KOCH	Koch, Mo.	Dr. G. D. Kettelkamp	Pneumothorax clinics Monday, Wednesday, Thursday and Saturday beginning at 8 a.m. X-ray films read Monday from 12:30 to 2 p.m. Thoracoplasties Tuesday and Friday mornings Staff conferences for discussion of patients Tuesday and Friday from 1:30 to 3 p.m.
ST. JOHN'S	307 South Euclid Ave.	Sister M. Bernardo	Modern obstetrical department
ST. LOUIS CHILDREN'S	500 South Kingshighway	Estelle D. Claiborne	Exhibit of toys suitable for children made by student nurses Exhibit of dangerous playthings for children Exhibit of economy measures Incubator for premature infants Simply constructed steam room for humidification
ST. LOUIS CITY, NO. 1	1515 Lafayette St.	Clinton F. Smith	Blood plasma bank
ST. LOUIS INFIRMARY	5800 Arsenal St.	John G. Steinle	Old peoples' home converted to a hospital for chronically ill Research department studying the aging process
ST. LOUIS SANITARIUM	5800 Arsenal St.	Dr. L. H. Kohler	Electric shock therapy with and without curare
ST. LOUIS SCHOOL OF OCCUPATIONAL AND RECREATIONAL THERAPY	4567 Scott Ave.	Geraldine R. Lermit	Educational poster exhibit
ST. MARY'S	6420 Clayton Road	Sister Mary Theobalda	Pediatric department Novel dietary organization Patients' library; full-time librarian; many rare volumes Nursing staff organization
ST. MARY'S INFIRMARY	1536 Papin St.	Sister Mary Celeste	Hospital for colored patients owned and operated by white Sisters Completely organized Negro medical staff School of nursing for colored students
ST. VINCENT'S SANITARIUM	Wellston Station	Sister Anne	Occupational therapy department Electroshock therapy
VETERANS' ADMINISTRATION	Jefferson Barracks	Dr. L. M. Cochran	Recreation building Occupational therapy department Patients' library of 6000 volumes for men Dietary building Pharmacy Dental clinic Physical therapy department X-ray department Laboratory New nurses' home

Convention in War Time ★

A.H.A. Convention Program

St. Louis, Oct. 12-16, 1942

MONDAY AFTERNOON, OCT. 12

Purchasing Section

Address: Priorities as They Affect the Hospital, W.P.B. speaker.

Address: Value of Purchasing Agent, Paul L. Burroughs.

Address: Basic Principles, Anthony J. J. Rourke, M.D.

Discussion: Charles O. Auslander, leader.

Quiz Session: Chosen experts in field.

Dietetic Section

Addresses: War-Time Adjustments in Hospital Kitchen—Food Outlook, Paul S. Willis; Personnel Equipment and Food Budget, Mary E. McKelvey; discussions by August E. Gilster, Louise Wilkinson, Anthony J. J. Rourke, M.D., and John B. Pastore, M.D.

Address: Food Cost Accounting in Dietary Department, Graham L. Davis. Discussed by Charles G. Roswell and Elizabeth Rugh.

Address: Rôle of Hospital in National Nutrition Program, Frances McKinnon.

Pharmacy Section

Address: Appraisal of Contribution of Pharmacy to Care of Patient, Ray M. Amberg.

Address: Luxury Drugs and Their Equivalents, E. Fullerton Cook, M.D.

Address: The Effect of War Production Board Orders on Hospital Pharmacy, Robert P. Fischelis.

Address: Pharmacy in War Time, E. F. Kelly.

Out-Patient Section

Addresses: Restatement of Duties, John V. Laurence, M.D.; Service to Poor; Relation of Dispensary to Hospital, Donald C. Smelzer, M.D.; Out-Patient Department in Small Communities, John Morrison, M.D.; Follow-Up Clinic, John Pastore, M.D.; Pay Clinic, George O. Whitecotton, M.D.; Maternal Guidance Clinic, Fred L. Adair, M.D.

Address: Out-Patient Department in War Time, E. M. Bernecker, M.D.

MONDAY EVENING, OCT. 12

President's Session

Presidential Address: Basil C. MacLean, M.D.

Response by President-Elect: James A. Hamilton.

Presentation of A.H.A. Award of Merit to Winford H. Smith, M.D.: Rt. Rev. Msgr. M. F. Griffin.

Presentation of National Hospital Day Awards: Albert G. Hahn.

Reception.

TUESDAY MORNING, OCT. 13

Hospital Service Plans Section

Address: Blue Cross in War Time, C. Rufus Rorem, Ph.D.

Address: Development of Medical Service Plans, John R. Mannix.

Panel Discussion: Abraham Oseroff, coordinator.

Tuberculosis Section—I

Address: Characteristics of Sanatorium Patient in Review, Emil Frankel, M.D.

Address: Theory and Practice of Infectious Precautions, Bess M. Ellison.

Address: Theory and Practice in Furnishing Unit, A. T. Laird, M.D.

Address: Tuberculosis Nursing From Viewpoint of Administrator, Robert H. Browning.

Address: Use of BCG Vaccinations Among General Hospital Personnel, Sol Roy Rosenthal, M.D.

Nursing Section

Address: Educating Nurses for Specialties, Sr. N. Berenice, R.N.; discussed by Edna S. Newman, R.N.

Address: Nursing Service in War Time—Military Nursing, Capt. Pearl C. Fisher; Civilian Nursing, Emilie G. Robson, R.N.; discussed by Nellie G. Brown, R.N.

Address: Recent Changes in Hospital Nursing Practice, Sr. M. Geraldine, R.N.

Panel Discussion: Analysis of Changes and Effect on Different Departments, Robert E. Neff; Mabel W. Binner, R.N.; Edna E. Peterson, R.N.; Elizabeth W. Odell, R.N.; H. I. Spector, M.D., and Anthony B. Day, M.D.

TUESDAY AFTERNOON, OCT. 13

Tuberculosis Section—II

Address: Effect of War on Tuberculosis in Europe, H. I. Spector, M.D.

Address: Tuberculosis Control Program of U.S.P.H.S., Herman Hilleboe, M.D.

Symposium on Miniature Films: Department of Dr. Fred Hodges of University of Michigan and Group from Wisconsin General Hospital and Medical School, including Drs. Harold Coon, Lester Paul and E. H. Jorris.

Address: Flaws in a Case-Finding Program Among Hospital Personnel, Howard Alt, M.D.

Public Hospital Section

Address: Why Has A.H.A. Failed to Interest Superintendents of Public Hospitals? Is Superintendent at Fault? B. W. Black, M.D.

Address: Does Public Hospital Have Special Problems? Has It Taken Its Place in Community Hospital Program? Should There Be a Public Hospital Section? R. C. Buerki, M.D.

Address: Hospital Internships as Related to Accelerated Medical Curriculum, H. G. Weiskotten, M.D.

Address: Public and Voluntary Hospitals Cooperate in Training of Intern and of Resident in Specialties, Joseph G. Norby.

Public Education Section

Address: Joint Program of Public Education for Hospitals and Blue Cross Plans.

Address: Need for Strong State Program in Public Education.

Address: Hospitals and Press.

War Problems of Hospitals

Panel Discussion: Francis M. Shields, Col. C. F. Shook, Col. James A. Crabtree and Everett W. Jones.

Open Forum.

TUESDAY EVENING, OCT. 13

Laywomen in Hospital Service Section

Address: B. W. Black, M.D.

Address: Problems of Medical Care and Hospital Service in War Effort, Charles P. Taft.

Address: China at War, representative of Chinese Embassy.

WEDNESDAY MORNING, OCT. 14

Accounting Section

Address: Introduction to First Accounting Section, Graham L. Davis.

Address: Machine Accounting as Means to Better Administration, S. Ellis Pierce; discussed by Carl I. Flath.

Address: Uniform Accounting as It Works in Canada, Percy Ward; discussed by Graham L. Davis.

Address: Accountant's Responsibility, Clayton Reed, C.P.A.; discussed by Stanley A. Pressler, C.P.A.

Address: Hospital Credits and Collections, Willis J. Gray.

Round Table.

Medical Record Librarians' Section

Address: Medical Chart as Mirror of Hospital Progress, Rev. Alphonse M. Schwitalla.

Address: Definition of Unit Record System in Light of Modern Hospital Construction, Mrs. Adaline K. Hayden, R.R.L.

Address: Medical Record in War Time, B. W. Black, M.D.

Address: Simplified Methods of Medical Charting and Recording, Alice Kirkland, R.R.L.

Address: Record Librarian's Contribution to Social Statistics. Sr. M. Servatia, R.R.L.

Panel Round Table: R. C. Buerki, M.D., coordinator.

Construction and Maintenance Section

Address: "Be Prepared Program" for Hospital, A. J. Hockett, M.D.

Address: Emergency Hospital Construction Under Lanham Act, V. M. Hoge, M.D.

Address: Emergency Hospital Planning in War Time, Marshall Shaffer.

Address: Modernization of Laundry, Joe R. Clemmons, M.D.

Discussion: B. W. Black, M.D.

Small Hospital Section

Address: Payment by Local Authorities for Care of General Hospital Patients Who Are Public Responsibilites, Marshall Pickins.

Address: Rôle of Small Hospital in Present Crisis, Malcolm T. MacEachern, M.D.

Address: Practical Administrative Policies, Max E. Gerfen.

Address: Diagnostic Service in Small Hospital, M. R. Kinde, M.D.; discussed by Joelle C. Hiebert, M.D.

Address: Yardstick for Measuring Efficiency of the Administrator, R. C. Buerki, M.D.

Laywomen in Hospital Service

Panel Discussion: Use of Volunteers, Herbert Schmitz, M.D., Mrs. John Reibold, George Bugbee, Sister Seraphia.

WEDNESDAY AFTERNOON, OCT. 14

Administration Section

Addresses: Personnel Problems in War Time—Changing Practices Necessitated by National Emergency, E. L. Harmon, M.D.; Making Greatest Use of Subsidiary Workers, Including Volunteers, Herman L. Mehring; Relationships of Purveyor and Manufacturer to Hospital Administrator, Howard F. Baer.

Panel Discussion: Business Management, Col. William E. Barren, Sample B. Forbus, George P. Bugbee, Ronald Yaw, John N. Hatfield, Donald M. Rosenberger, Dorothy H. McMasters, William P. Butler, Carl P. Wright, J. T. Tollefson.

WEDNESDAY EVENING, OCT. 14

Trustees' Section

Address: Hospital as a College, Alan Gregg, M.D.

Address: Volunteer Workers, Mrs. Edward J. Walsh.

Address: Public Relations, Ralph W. Harbison.

Address: Selection of the Administrator, Malcolm T. MacEachern, M.D.

THURSDAY MORNING, OCT. 15

Medical Staff Section

Address: Relation of Hospital to Outside Practitioners, Joelle C. Hiebert, M.D.

Address: Status of Dental Service in Hospital, B. E. Lischer, M.D.

Address: Hospital's Responsibility in Postgraduate Education of Visiting Staff, Frank R. Bradley, M.D.

Address: Hospital Medical Staff in War Time, Charles F. Wilinsky, M.D.

Panel Discussion: Education of Interns and Residents, Byron L. Robinson, M.D., Maurice H. Reese, M.D., J. R. Smiley, Erwin C. Pohlman, A. G. Stasel.

Children's Hospital Section

Round Table Discussion: Gladys Brandt, Mabel W. Binner, Mildred Riese, Margaret A. Rogers, Emma Sargent, Rev. J. G. Snelling, DeMoss Taliaferro, Moir P. Tanner, Harry B. Torrey.

Social Service Section

Address: Medical Social Service in War Time—With Army and Navy, Lena Waters; in Civilian Hospital, Ida M. Cannon.

Address: What Is Efficient Organization for Medical Social Service? F. Stanley Howe.

Address: What Clinical Staff May Expect of Medical Social Service Department? Mary K. Taylor; discussed by James A. Hamilton, Theodate Soule, Rev. Alphonse M. Schwitalla, Edith G. Seltzer.

THURSDAY AFTERNOON, OCT. 15

Hospitals at War Session

Address: Procurement of Medical Personnel for Military Service—Hospital Relationships, Col. Sam F. Seeley, M.D.

Address: Medical and Hospital Service in the Air Force, Brig. Gen. David N. W. Grant.

Address: Hospital Cooperation in Civilian Defense, Col. George Baehr, M.D.

Address: Grants-in-Aid Program to Assist Hospitals in Establishing Blood and Plasma Banks for Emergency Medical Use, Victor H. Vogel, M.D.

Address: Hospital Care for War Casualties—A Challenge to Hospitals, Their Doctors and Their Nurses, Capt. Florence MacDonald.

Address: British Hospitals After Three Years of War, Prof. William M. Frazer.

Address: The War—Calamity or Opportunity? Fred G. Carter, M.D.

THURSDAY EVENING, OCT. 15

Banquet and Ball

Banquet Speaker: Paul V. McNutt.

FRIDAY MORNING, OCT. 16

War Problems Round Table

Coordinators: MacEachern and Jolly.

A.C.H.A. Program

SUNDAY, OCT. 11.

General Business Session

Hotel Jefferson, 10 a.m.

Reports of officers and committees. Election of officers.

Convocation

Hotel Jefferson, 2:30 p.m.

Installation of 37 new members, advancement of 23 nominees to membership and acceptance of 54 nominees.

Granting of honorary fellowship to Dr. Winford H. Smith.

Convocation Address: Doctor Smith.

Annual Banquet

Hotel Jefferson, 7:30 p.m.

Address: Conflict in the Pacific, Dr. Walter H. Judd, Minneapolis, formerly medical missionary in China.

Presidential Address: Joseph G. Norby, Milwaukee.

President's Reception

Hotel Jefferson, 9 p.m.

MONDAY, OCT. 12

General Educational Session

Municipal Auditorium, 9:30 a.m.

Topic: Public Health and the Hospital Administrator — Present and Future Trends. Discussed by Ira V. Hiscock, D.Sc., New Haven, Conn.; Charles F. Wilinsky, M.D., Boston, and Basil C. MacLean, M.D., Rochester, N. Y.

Protestant Program

SATURDAY, OCT. 10

Morning Session

Crystal Room, Hotel Jefferson, 9:30 a.m.—12:15 p.m.

Chairman: E. I. Erickson, Chicago.

Report on Defense and Legislation: John G. Martin, Newark, N. J.

Address: How the Protestant Hospitals Can Encourage the Work of the A.M.A. Specialty Boards, Robin C. Buerki, M.D., Philadelphia.

Address: How Can a Church Hospital Meet Its Obligation to Finance Charity Patients? Claude W. Munger, M.D., New York City.

Address: What Can Be Done to Secure More Endowment Funds? Ella Mae Bergner, New York City.

General Topic: What Can We Do to Develop a High Standard of Christian Spirit and Service in the Protestant Hospital?

Address: From the Standpoint of the Administrator, Rev. Joseph A. George, Chicago.

Address: From the Standpoint of the Nurse, F. Jane Graves, Alton, Ill.

Address: From the Standpoint of the Physician, C. S. Woods, M.D., Peoria, Ill.

Round Table Conference

Crystal Room, Hotel Jefferson, 11:15 a.m.

Coordinators: M. T. MacEachern, M.D., Chicago, and Robert Jolly, Houston, Tex.

Topic: The Effect of the War on the Protestant Hospital.

Luncheon.

Afternoon Session

Crystal Room, Hotel Jefferson, 2 p.m.

Chairman: Rev. John L. Ernst, Detroit.

Officers and Committee Reports.

Report of the Commission on Religious Work in the Protestant Hospital, Rev. Seward Hiltner, New York, and Russell L. Dicks, D.D., Dallas.

Panel Discussion and Symposium: Special Study on Religious Work.

Banquet

Crystal Room, Hotel Jefferson, 7 p.m.

Presiding: John H. Olsen, president.

Addresses: Basil C. MacLean, M.D.; M. T. MacEachern, M.D.; Lucius R. Wilson, M.D.; Rev. Alphonse M. Schwitalla, St. Louis.

Dedication of Association Flag: Rev. Paul R. Zwilling, St. Louis.

Address: The Military Hospital, Col. Lee Gammill, Washington, D. C.

Address: C. O. Johnson, D.D., St. Louis.

SUNDAY, OCT. 11

Morning Worship Service

Crystal Room, Hotel Jefferson, 9-10 a.m.

Presiding: Edgar G. Blake Jr., Chicago.

Address: W. W. Martin, St. Louis.

A.A.N.A. Program

MONDAY, OCT. 12

Registration and Exhibits.

General Session

Address of Welcome: William D. Becker, mayor of St. Louis.

Greetings From A.H.A.: Basil C. MacLean, M.D., Rochester, N. Y.

Address: The Surgeon's Responsibility in Anesthesia, Nathan A. Womack, M.D., St. Louis.

Address: The Therapeutic Value of Oxygen, Esther C. Myers, Detroit.

Address: Ethics for the Anesthetist, Sister John Edward Kaiser, Cincinnati.

Tea

Statler Hotel, 4:30-6 p.m.

TUESDAY, OCT. 13

Business Session

Presiding: Helen Lamb, St. Louis.

Officer and Committee Reports.

General Session

Address: Obstetrical Anesthesia and Analgesia, Frances Kocklauner, Cleveland.

Address: Evarts A. Graham, M.D., St. Louis.

Address: Anesthesia in Relation to Neurosurgery, Ernest Sachs, M.D., St. Louis.

Address: The Use of U.S.P. Bulk Ether for Anesthesia, Albert Snoke, M.D., Rochester, N. Y. Discussion by L. H. Wright, M.D., New York City.

WEDNESDAY, OCT. 14

General Session

Coordinator of Panel Discussion: Miriam G. Shupp, Rochester, N. Y.

Participants in Panel Discussion: Florence King, St. Louis; Duff Allen, M.D., St. Louis; Rosalie C. McDonald, Emory University, Ga.; Lola Baird, St. Louis; A. Johnson, St. Louis.

General Session

Address: Physiology, Cordelia Bakes.

Address: Anesthesia in Perioral Endoscopy and Laryngeal Surgery, Rowena Kling, New Orleans.

Address: The Nurse Anesthetist in the Hospital, Frank Bradley, M.D., St. Louis.

Address: The Army Nurse Anesthetist, Robert Elman, M.D., St. Louis.

Banquet

THURSDAY, OCT. 15

Visits to clinics.

BARNES *Centralizes Laboratory Service*

F. R. BRADLEY, M.D.
BARNES HOSPITAL, ST. LOUIS
SUPERINTENDENT

THE INCREASE in hospital occupancy and the rapidly changing economic and personnel problems that began even before the war have made it necessary to reconsider the efficient operation of our clinical laboratories. We feel that there is nothing unusual about what we have done at Barnes, for the change was made slowly and after considerable study and consultations following visits to other laboratories. However, while our problem may be rather peculiar to the larger and teaching institutions, many of our ideas came from small hospital laboratories.

The centralization of our laboratories began July 1, 1941, when Barnes Hospital took over the laboratory service for Barnes Hospital and the Washington University Clinics, including surgical pathology for surgery and for gynecology in the affiliated hospitals of the group.

Prior to that time, the laboratories were conducted by the Washington University School of Medicine. Each department of the school did its special work, and the natural result was: (1) the laboratories were widely separated from one another and in many instances were located at considerable distances from the wards and clinics they served; (2) tests done in the clinic were often duplicated in the hospital and vice versa; (3) no general secretarial staff and no adequate messenger service were available; (4) reports came in late and often were not available to the staff; (5) the laboratories were on restricted time—open from 9 a.m. to 5 p.m. and closed on Saturday afternoons, Sundays and holidays.

Briefly, the major changes were: (1) relocation of the clinical laboratories in a central and readily accessible place in the hospital; (2) the organization of a general secretarial staff serving the entire laboratory and hospital; (3) extension of the hours of service from 8 a.m. to 10 p.m. daily (a skeleton crew remains on duty from 5 p.m. until 10 p.m. and on Saturday afternoons, Sundays and holidays); (4) organization of a blood bank.

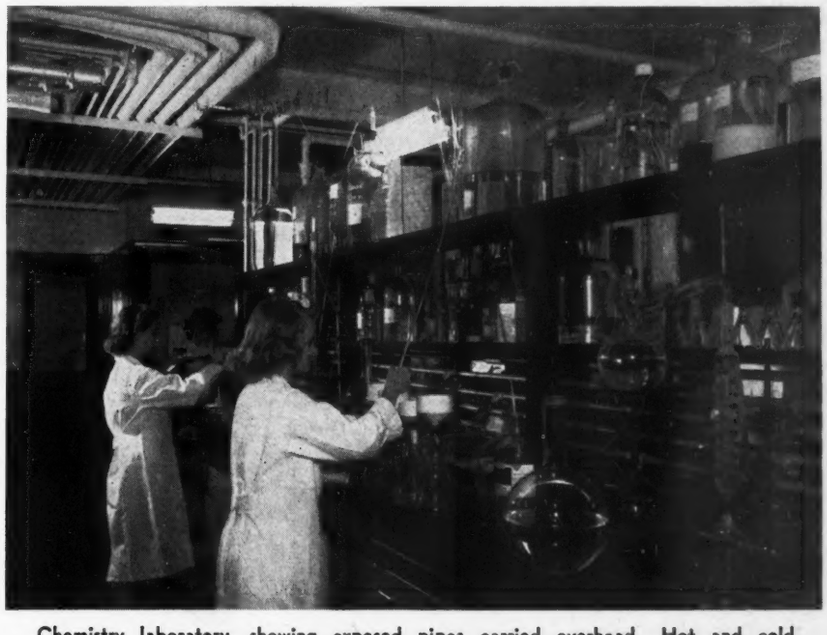
No change was made in the professional personnel or in the excellent technical procedures.

The laboratory load is that of a teaching hospital—200 of the 425 Barnes Hospital beds are ward beds used for the care of patients and for clinical teaching by the school of medicine. Therefore, on ward patients, a considerable part of the routine laboratory work, such as urinalysis, blood counts, sputum examination, stool examination and tests for kidney function, is being done by medical students and interns. Other laboratory work, such as blood chemistry, is done by the laboratories.

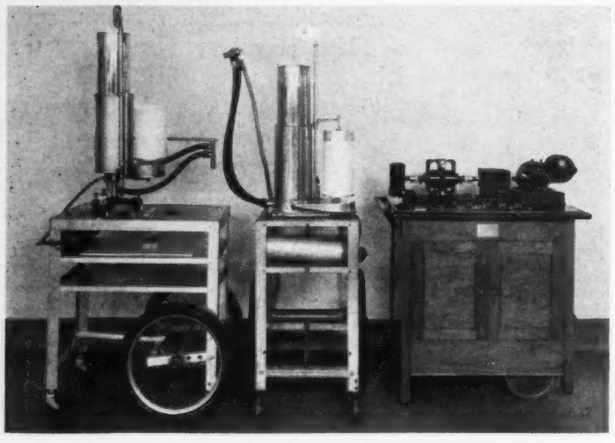
On private patients, the laboratory work is the responsibility of the technician except when the laboratory is closed, at which time the house or intern staff is required to do emergency laboratory work. The laboratory work for the private doctors' offices, serving private outpatients, averaging 1200 visits a month, is done by the laboratory.

It is the duty of the secretaries from the central laboratory office to make frequent rounds and transcribe the laboratory reports into the body of the patient's hospital record. This ensures promptness and accuracy and saves the time of the doctor, intern and nurse. In this manner, reports are almost invariably in the record even on the day of discharge, which relieves the record room of much responsibility and detail. Secretarial work is performed in the other departments, such as surgical pathology, heart station, basal metabolism, but the data are brought to the central office for distribution. The telephones are centralized at the general office; there is a 12 line station using two 6 line key cabinets.

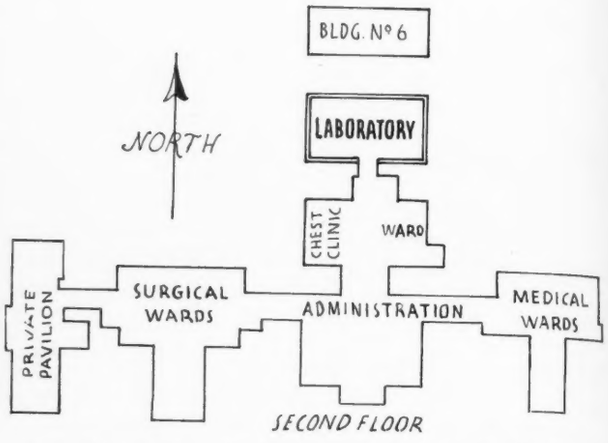
All charges for laboratory work originate in this office. A ledger for each patient is kept. Charges are posted to it and turned in to the



Chemistry laboratory, showing exposed pipes carried overhead. Hot and cold water, gas, compressed air and suction are piped on the laboratory table.



End and side views of the portable basal metabolism machine (left) and the large sized electrocardiograph machine (right).



Floor plan showing the location of the centralized laboratory in relation to the other buildings of Barnes Hospital.

cashier at the end of the day for charging to the patient's account. The cashier can call for charges on patients from 8 a.m. to 5 p.m. This is a distinct advantage when the patient is leaving the hospital.

The room where blood is taken from donors contains six beds. The full capacity is 12 donors per hour on the basis of thirty minutes' bleeding time required per donor. Rubber sheets are used at the foot of the bed so that it is unnecessary to change the bed linen for each donor. Small hand towels are placed on the pillow and changed for each donor. This obviates the necessity of changing the pillow slip frequently. The cubicle arrangement gives ample privacy. This room connects directly with clinical microscopy, where the blood is stored in the refrigerator.

The aim in designing the blood chemistry laboratory was toward both precision and efficiency in the conduct of the work. Space and operations are so related that work may proceed on an "assembly line" technic. Unnecessary motion is reduced to a minimum.

All specimens enter the line at the same place. Immediately adjacent is the space for precipitation of blood protein. Here are various types of apparatus designed to facilitate rapidity of measurement.

Since blood sugar determinations are made in great numbers, they may serve as good illustration of procedure. One finds, moving to the right, first an area for the filtration, which must follow the precipitation, and automatic pipettes for measuring the reagents for sugar determination. Farther to the right are the boiling water baths under a small hood and, beyond these, a bath of running water for cooling. Next is the arrangement for adding the last reagents and finally the burettes for titration. While one chemist is making the titrations, another is making the calculations. When a series is completed, the first chemist checks the calculations of the second.

Certain determinations are sidetracked at various stages to individual minor "assembly lines." Most of these are on the work space running parallel to and opposite the first. A few, requiring more space or cumbersome apparatus, are transferred to other parts of the laboratory. Gasometric analyses by the Van Slyke technic are made at the end of the space between the two main work benches. About 20 per cent of the laboratory is devoted to the checking and investigation of methods and to research.

The reorganization and centralization of the laboratory made possible many time-saving methods. In many hospitals, particularly large or teaching hospitals, the patient is taken to the different laboratories for tests. This creates several complex problems of transportation, time and coordination. There are even psychological problems based on the patient's reaction to the tedium of delay, the discomfort resulting from jolting and jumbling of equipment in the elevators, the strange surroundings and apprehension.

How much simpler if the laboratory technician can come to the patient! In solving the problems of doing basal metabolism tests at the bedside, the chief one was in making the equipment portable. That presented no great difficulty and was solved by putting apparatus of the water type on a rubber-tired carriage. Much clinical time is gained by doing basals in the patient's room after the patient has had ten hours' rest in bed and immediately upon awakening. The technician may begin on the wards as early as 5:30 a.m. and on the private corridor from 6:30 a.m. to 7 a.m. There is no sense of delay to the patient because he is in his own bed and usually asleep.

Just as soon as the basal is finished, other laboratory procedures, such as fasting blood sugars and blood counts, may be done immediately. The technician can, by properly scheduling basals, do all the tests on one floor and proceed to another floor in the same building. Our experience has been that the average number of portable basals that can be performed is three per hour.

The results of the centralization of the laboratories have been sound and productive. As planned, the days' stay in the hospital has been appreciably decreased. It may seem paradoxical, but in some instances centralization of the laboratories has had the surprising result of enabling us to decentralize some of our laboratories, especially basal metabolism and electrocardiography. Reserve space and flexibility are provided so that future changes may be made subject to growth, additional experience and more mature judgment.

ACCOUNT NO. 300

ANALYSIS LEDGER

SHEET NO. 1

ACCOUNT Gross Earnings From Hospital Service

	DATE 1942	EXPLANATION	REF.	DEBIT	CREDIT	DR. OR CR.	BALANCE	DAY RATE SERVICE Priv.Rms. 311	Semi-Priv. 312	Wards 313	OPERATING ROOM In-Pat. 3211	Out-Pat. 3212	Priv.Amb. 3213
1	Jan 31		CJ1		239 1 37			405 00	314 50	385 00	134 2 00	27 50	-
2	Feb 28		CJ1		273 09 3 14			384 00	297 50	387 1 50	116 4 50	24 50	-
3													
4													

ANALYSIS

SHEET NO. 1

ACCOUNT Gross Earnings from Hospital Service

	Del. Rm. 322	Nursery 323	X-RAY SERVICE In-Pat. 3241	Out-Pat. 3242	Priv.Amb. 3243
1	633 50	499 50	1675 50	798 50	567 70
2	667 50	627 50	1874 50	902 35	625 00
3					
4					

This System Saves POSTING

ROBERT PENN, C.P.A.

HOSPITAL ACCOUNTING CONSULTANT, CHICAGO

TO FURNISH the administrator and trustees of a hospital with complete financial information concerning the operations of the hospital, it is necessary to maintain a considerable number of bookkeeping records. Too often, hospital accountants, bookkeepers and cashiers are swamped with detail which inevitably results in neglecting other necessary work, such as collection of patients' accounts.

A number of methods may be suggested for reducing to a minimum the clerical work involved in maintaining proper and adequate accounting records. In many instances it will be found possible to improve the system and yet devote less time to its maintenance.

It is a common practice, for example, to use a ledger sheet that shows the date, explanation, debit, credit and balance for each asset, liability, income and expense account in the general ledger. Most of the postings to the general ledger are to the income and expense accounts. If the chart of accounts recommended by the American Hospital Association in "Hospital Accounting and Statistics" is expanded for use by the average 75 to 150 bed hospital, the gross income and operating expense accounts will probably number about 32 and 132, respectively. In other words, a chart of accounts including such gross income and operating expense accounts would require 164 ordinary ledger sheets.

By using one analysis ledger sheet for the gross income accounts and 21 similar analysis ledger sheets (one for each department) for operating expenses, the posting of 142 dates and references is eliminated each month, which is a big timesaver. Furthermore, fewer sheets need to be handled, which speeds up posting considerably. In addition, each analysis ledger sheet for operating expenses automatically furnishes the total direct expense of each department. It will also be found that the use of analysis ledger sheets in the manner illustrated will aid considerably in drawing off trial balances and preparing financial statements.

Moreover, analysis ledger sheets can be used to advantage for certain asset and liability accounts, such as inventories, fixed assets and reserve for depreciation and analysis of surplus.

Another labor-saving device in connection with the general ledger is the visible record. This type of form can be used to advantage when it is necessary or advisable to have a ledger sheet for each account. Visible binders are made in various sizes so that from 17 to 33 accounts, depending on the size of the binder, can be seen at a glance.

To prove the arithmetical accuracy of the postings to the general ledger, a trial balance is drawn off each month. The accounts are generally listed in a trial balance book and the amounts are inserted each month. The income and expense accounts comprise the major portion of the general ledger accounts and, since they are the most active accounts, errors in posting will be found largely in this group.

Is This a National Tragedy?

E. A. VAN STEENWYK
EXECUTIVE DIRECTOR, ASSOCIATED HOSPITAL SERVICE OF PHILADELPHIA

ONE may be pardoned for approaching the Social Security Board's hospital care proposal with diffidence. The need for a temperate approach, for remembering that those who hold opposite points of view for any reason are as sincere, as intelligent, may in fact have a broader vision, is apparent to anyone.

Not economic problems alone are under consideration. This proposal involves more than rates of payment to hospitals and methods of taxation. We are really considering a change in our way of life which forces us to speak out for what we believe.

At the conference of Hospital Service Plans held in March a six point program, urging the cooperation of the federal government in financing hospital care of public assistance groups, as well as other needy persons, and urging deferral of the proposed plan, was adopted. This program in no way suggests a denial of the federal government's right to enter this field nor has such a denial come from responsible service plan quarters. There has been no disposition on the part of the Hospital Service Plan Commission to consider the social security proposal on any basis except its merits.

The position of the Blue Cross and hospitals in such a discussion is not motivated by narrow business interests or the mere desire to maintain the status quo. If there has been any single enterprise in American life during the last ten years that has demonstrated the resourcefulness of the American people in meeting their problems without governmental assistance, it has been the hospital sponsored Blue Cross. While it made no claim as a social service agency, most social workers have been quick to recognize that by removing the chief cause of the pauperization of millions of families—the hospital bill —Blue Cross has made a significant social contribution.

Its uniqueness and strength have been due to the fact that each Blue Cross plan is independent, each meets the problem of its own community, welding into effective relationship hospitals, physicians and subscribers while preserving the independence of each in a free and open market. While Social Security Board spokesmen have insisted that their program would not impede the progress of Blue Cross plans or lessen the character of the voluntary hospital, one need only recall the many instances in which government financing has resulted in government control.

We have all been New Dealers of a kind during the last ten years, eagerly accepting the leadership of the first third-term president of our nation in a time of great national and international stress. The social legislation adopted in America during this time was overdue. Men of vision were needed to fan the sparks that had been struck. But President Roosevelt when he first took office gave expression to a philosophy that should now sustain the voluntary hospital. In a great affirmation of the American spirit in a very difficult time he said: "The only thing to fear is *fear* itself."

Why, with these social gains so well under way, should we now shrink from going all of the way? What is the difference between old age insurance, unemployment insurance and health insurance? Is not much of the distress of poverty, disease and even crime manageable if health can be assured to the American people? Isn't it true that for millions of Americans only lack of money stands in the way of the receipt of adequate care? Is not a compulsory health insurance scheme the only way in which this deterrent can be removed? Let us see.

It is generally conceded that America has the finest facilities for providing hospital and medical care in the world. Its medical profession is well trained and offers as high a level of service as is offered anywhere.

A federal official has estimated that rural areas need 270 more general hospitals with 15,500 beds. These are small figures compared to the existing 4518 general hospitals with 533,498 beds, among which voluntary institutions number 2350 with 252,790 beds. This does not indicate serious inadequacy on the part of our voluntary hospital facilities. Rather the facts point to serious inadequacy in governmental facilities—50,000 more beds needed for the tuberculous and 130,000 for nervous and mental disease patients.

I do not argue that all is well—the facts argue for themselves that the trend of voluntary institutions is encouraging. With wider participation of the population in the Blue Cross plans (so that hospital bills can be paid) general hospital facilities will be built without government aid.

While the Blue Cross idea is relatively new (it did not really get under way until about four years ago), it has already enrolled more than 10,000,000 subscribers. More than 80 per cent of all voluntary hospitals of our country are now members in nonprofit plans. Plans are now established and rapidly gaining enrollment in areas which include more than 90 per cent of the population. Only a few areas, such as Indiana and Nevada, have not yet made legislative provision for this approach to the problem which the Social Security Board now acknowledges by proposing a substitute hospitalization payment of $3 per day.

Although I do not want to consider for too long the details of the board's program, it should be pointed out that hospital bills for one day of care not infrequently exceed $25. The average for six days is approximately $50. Fifty per cent of all subscribers hospitalized under Blue Cross plans remain in the hospital for six days or less. The social security plan as proposed would pay $3 toward one day of hospital care; $6 toward the cost of two days, and so on up to $18 for six days.

The American system of working, spending, saving as one chooses has become a cherished right. Does the Social Security Board's proposal presage an end to this individualism?

The average citizen admitted to the voluntary hospital under the social security plan would be required to pay the remainder of such a bill. For the hospitals trying to collect the difference, the explanation that full payment was never intended under the social security plan or that the tax was essentially a part of an anti-inflationary program would leave room for small comfort indeed. Blue Cross plans have clearly shown that hospital care insurance is good only to the extent that hospital service contracts—not cash indemnification—are provided.

The Social Security Board has indicated that at the present time the complications of developing service contracts with hospitals is administratively too complicated. If those who oppose the social security program are subject to the charge that they oppose it for personal reasons, what shall be said of an agency that for expediency makes so fundamental a compromise as to result in hopelessly inadequate hospital service? Effective demonstration cannot be made that an inadequate hospital payment plan is better than none if the inadequate plan imperils hospital standards by not meeting reasonable hospital costs.

A good demonstration can be made of effective utilization of part-pay plans aiding in the financing problem of hospitals of governmental and private agencies. But it must be remembered that the different kinds of part-pay plans represented by the Duke Endowment to Carolina hospitals on a per diem basis, the commonwealth of Pennsylvania on a biennial basis, the city of New York on a per diem basis are all demonstrations of a desirable social policy overlaid upon a system which does not in any way make it difficult for hospitals to obtain the remainder of its costs from either private patients or private philanthropy.

It is said that the social security program will not be presented as a full-pay service plan. Yet when hospitals must collect from 30 to 75 per cent of most hospital bills from the patients, this assertion will be of little aid in obtaining understanding and payment. As a social policy it is much better to have a secure umbrella that fully protects those who seek its shelter than to have a broad expanse of cheesecloth spread willy-nilly over the entire populace.

If the Social Security Board proposal is enacted into law by Congress, will hospitals still obtain support from private philanthropy? Will physicians continue to make their contributions in time and effort now made to voluntary hospitals?

In Philadelphia 80 per cent of all hospital beds are ward beds in which more than half of the patients do not pay medical fees. The merits of continuing such a system of financing medical care may be questioned, and ought to be, but this problem, too, is being solved on a voluntary basis so that the tin-cup philosophy of providing care to the needy need not be with us forever. The economic problems of distributing care and paying physicians can be solved upon a voluntary basis if the people really want this service and will pay for it.

No one would seriously contend that broad distribution of inadequate benefits is better than limited distribution of adequate benefits if there is a trend that is encouragingly toward wider distribution of these adequate benefits. Already many Blue Cross plans have enrolled from 25 to 50 per cent of the entire population in their areas. It is not too optimistic a view to expect eventual participation of at least 50 per cent of the American people in voluntary plans. This still leaves a big job to be done by governmental agencies among those who cannot be enrolled because of their financial, health or age status or type of employment.

As a representative of a Blue Cross plan, I am not against government participation in providing care to those who cannot be enrolled in voluntary plans. It is my belief, however, that a much more imaginative utilization of manpower and facilities can be obtained if the rest of the job is left to the people themselves. The sum of $100,000,000 obtained from general taxes or a sales tax could provide hospital care to the needy and those in various public assistance categories. A compulsory health insurance plan for all of the people is not necessary when the economic problem boils down to this kind of an assistance program.

American people are not afraid to meet the tax burden of the war. They want the continuation of the American system and will pay in blood and money whatever the price without the necessity of being taxed under a subterfuge. The problems resulting from increased income taxes are less acute for hospitals than for other voluntary agencies. After all, hospitals provide a service comparable to other services which people regularly buy and for which they assume responsibility to pay.

The Blue Cross plans in 1942 will pay hospitals approximately $50,000,000. This is not a small sum when it is realized that all the Community Chest campaigns in America do not produce more than $7,500,000 a year for hospitals.

We believe that voluntary hospitals, private physicians and the people of this country can by themselves solve the problem of distributing hospital care to all but the relief families. No magical solution to the problems of financing hospital care is going to be pulled out of a legislative hat. The touchstone of compulsory participation will not give off miracles that cannot be achieved by voluntary means. But we cannot be afraid. As hospital representatives we must renew our confidence in American people, realize again and again that the American people will pay for the service that they want, that the American people do not look to the government for any service which can be done by the people themselves.

WE HAVE *a child guidance clinic*

RALPH J. SLATTERY, M.D.

ANALYTIC PSYCHOLOGIST, CHILDREN'S HOSPITAL, COLUMBUS, OHIO

SOME of the most effective and valuable work in correcting or preventing personality disorders, with their subsequent histories of delinquencies and neuroses, is done in child guidance clinics. But the cost of establishing and maintaining such a clinic is generally so high that large funds must be available, either in the form of income from heavy endowments or in the form of tax allocations. The services afforded by child guidance clinics are available, outside these clinics, only to families in the upper income brackets, but the need is just as great among people in the average or lower income groups.

The high cost of maintaining buildings and engaging the services of specialists makes financing these clinics difficult. The minimum requirement for an adequate child guidance staff is a psychiatrist, a psychologist and a psychiatric social worker. With the exception of the services of an analytical psychologist, Children's Hospital, Columbus, Ohio, already fulfilled all the necessary requirements and, in addition, had numerous other services and clinics to minister to the health and welfare of children.

The establishment of our clinic thus represents another step in the steady progress of our hospital. By integrating the work of a child guidance clinic with the services already offered by the hospital, the clinic can be built up without incurring the heavy costs of a separate establishment and independent staffs. Economy of operation, however, is not the only advantage of this plan.

The health value of the other clinics and the other services of the hospital is much better recognized by the public than are the services of child guidance. The long-established services of the hospital have brought it considerable prestige. A child guidance clinic, under the sponsorship of the hospital, will receive the initial advantage of the favorable attitude with which the public regards the hospital. Moreover, most sound growth is gradual growth and the hospital affords the added advantage of permitting the child guidance clinic to begin on a modest scale and to develop in accordance with discovered needs.

Under the direction of Eva Ellen Janson, superintendent of the Children's Hospital, there has been a steady increase in the scope, the magnitude and the excellence of the hospital's services. In Miss Janson's vision of the function of the hospital in community life, she has emphasized the idea that one of the hospital's most important purposes is that of keeping the child well. This is largely the work of the outpatient department. Families, therefore, are used to approaching the hospital for help in seeing that the children are kept well. Therefore, it is not difficult for people to become accustomed to seeking the services of the child guidance clinic established at the hospital. The clinic is also of great help to the children who are hospitalized.

The child guidance clinic cooperates with the pediatricians, the neurologists, the psychiatrists and the medical social workers in making a study of the whole child and in administering to his health needs. In carrying out its program, the clinic is greatly aided by the hospital's fine social service department. The child's development has many and complex connections with the inter-relationships among the members of the family and with the status and the environment of the family. To the proper functioning of a child guidance clinic, social service work is indispensable.

A child guidance clinic serves two important functions: (1) helping to resolve the behavior problems of the children who are referred to the clinic and (2) bringing about a better understanding of the needs of child life. This second function is particularly significant in the relationship of the child guidance clinic to professional groups, such as teachers, social workers, court workers and others who have to deal with children's behavior difficulties.

In the course of time, the clinic will build up sound working relationships with the schools and day nurseries, the children's homes, the Aid to Dependent Children's Bureau, the Family and Children's Bureau and the juvenile court. These agencies not only minister to children's physical needs but also build character. In its twofold function, the work of the clinic is facilitated through its association with the Children's Hospital; this association embodies the ideal viewpoint that the welfare of the child is dependent upon both physical and mental health.

The question of how to coordinate all these forces so as to give the public the resources of the child guidance clinic at low cost and to make it possible for people in average or in lower income brackets to have advantage of psychological service in the upbringing of their children is still unsolved. This problem is part of the growing pains of the clinic and can be worked out only in the course of its actual operation.

The aim of a child guidance clinic is to help ensure the healthy normal development of the child by aiding him in removing those emotional tensions that would otherwise arrest his proper adjustment to life. An associated aim is that of aiding parents and interested social agencies to recognize any important environmental barrier to a particular child's adjustment.

In life, the individual, from the beginning to the end of his existence, is faced with problems. So long as he is adequately meeting these, he is free of emotional disturbance; he enjoys life and may even be unaware of the fact that any problems exist. When the individual fails in any

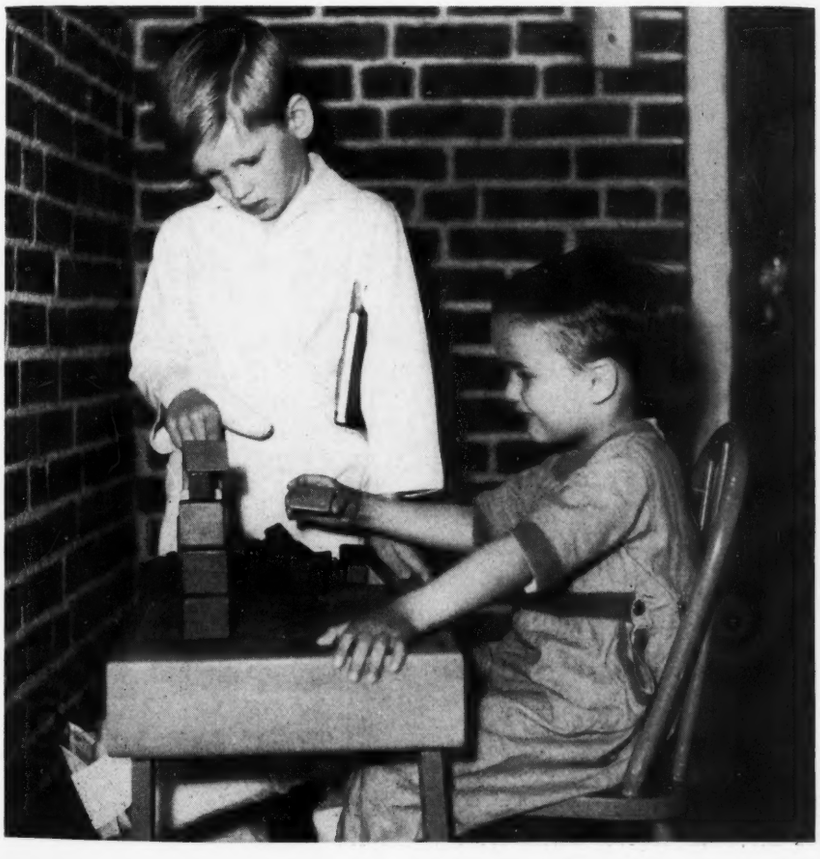
☆ *The Golden Age for mental hygiene is the age of childhood when disorders easily corrected prepare the child for a rich, balanced life*

matter of importance to him, an emotional state, such as anger, fear, hatred or resentment, arises. For the greater part, these emotional reactions are worked off in some manner or other. If, for example, a child falls, even though he is not hurt, he may give vent to his emotional reaction by crying.

Often, however, there are barriers to the satisfactory expression of the child's emotional state with the result that a more or less pronounced bias is given to the child's emotional life. The failure to have the emotional need satisfied may thus result in a serious interference with the child's normal adjustment. If the root of the matter is not discovered and remedied a behavior difficulty may be created and may continue into adult life. Instances of this sort, which might seem trivial to the adult mind, can be detailed in variety.

Here is one example. When Charlene was 3 years old, a baby brother was born. The infant became the center of the parents' attention. Charlene could not get to her parents and these emotional needs went unsatisfied. Shortly, Charlene exhibited such symptomatic behavior as pushing her dolly cart into the bushes and, when opportunity arose, pushing the baby carriage into the bushes, too. This behavior, not understood by the parents, was occasionally punished. Punishment, since it did nothing to alter the unconscious motivation of Charlene's acts, only served to redirect the expression of her urge.

At 14, Charlene found it very difficult to get along with other children because of her quarrelsomeness. She also found it difficult to establish good relationships to adults. She carried over into the world outside the home those apprehensions about adult attitudes that had been fostered by her lack of relationships to her parents. It was at the age of 14 that psychological treatment began and produced excellent results.

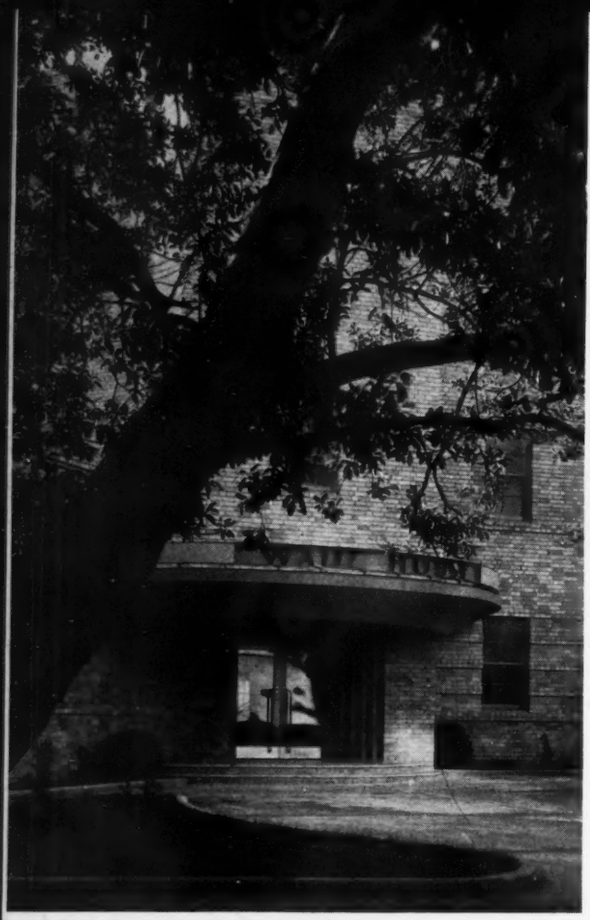


There are many connections between mental health and physical health. Physical disorders may be the outcome of emotional disorders. The emotionally maladjusted child is subject to strong emotional reactions even in situations in which emotional responses are not aroused in the average child. When the child is too frequently stimulated by strong emotional reactions a harmful effect upon health will result, for the emotions involve excessive stimulation of the visceral function and disturb the digestive processes. In the course of time, well-defined physical disorders may arise.

Of course, only the physician is competent to judge whether the child needs physical treatment. For this reason, the welfare of the child requires that the analyst work in close conjunction with the physician. All kinds of sicknesses are likely to predispose the individual to emotional disturbances which may either retard convalescence or continue after physical health has been restored. Even when the disorder is of physical character, the psychologist may be helpful in getting the child back to normal.

The importance of meeting the behavior problems of children as soon as these show themselves and the importance of making the public conscious of the great value of mental hygiene in childhood cannot be overstressed. It is well recognized by all authorities that the Golden Age for mental hygiene is the age of childhood.

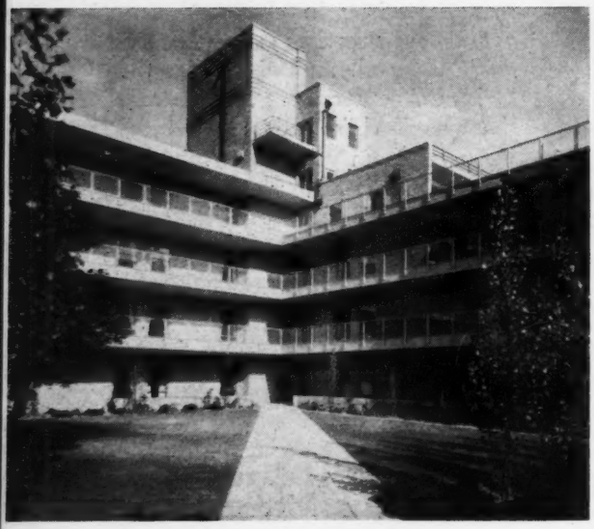
Apart from the humanitarian ideal of making life as rich as possible, there is also the monetary fact that the burden of providing for an adult mental case is far greater than the cost of administering remedial measures at an early period, when there is also the greater prospect of successful results. It is a program based on these ideals that is the motive behind the child guidance clinic of Children's Hospital.



Storybook Friends Frolic on the Walls of Wade House

PLANNED to create an impression quite the opposite of that which a child would associate with the word "hospital," Wade House, situated on the grounds of the Royal Alexandria Hospital for Children, Sydney, Australia, expresses some of the latest developments in hospital construction and equipment. The building is L-shaped, four stories high.

Views, starting above and reading counterclockwise, are: 1. The lobby where the child patient meets his fairy story friends who decorate the walls. 2. The main entrance to Wade House. The wrought iron name plate is illuminated at night. 3. A corner of the playroom where children find portrayed Peter Pan, the fairies, monkeys perched on cupboards, dancing butterflies and Little Bopeep. This room is equipped with toys for boys and girls of all ages. 4. Wade House from the sun court; the balconies face north and east. 5. A little patient admiring one of the mural decorations in the main lobby. 6. The ambulance entrance and the porte-cochere, which protects patients during ambulance loading.



Consultation Service—

WHEN and HOW?

It is wholly within the prerogative of the hospital's board of trustees to insist that sound group medicine be practiced

JOSEPH C. DOANE, M.D.

THE original purpose of creating hospitals was not only to increase the efficiency of treatment by collecting the sick into one place where apparatus and instruments could be assembled but chiefly to enable physicians to give the greatest amount of time to the individual patient.

A hospital staff consists of a collection of specialists. Each individual in a departmentalized staff setup is appointed because he is able to render a peculiar and specialized service to the patient. A specialist should be a physician well grounded in the basic sciences, who is spending a major portion of his time in the diagnosis and treatment of one particular type of ailment.

Although a large number of specialists comprise the hospital staff, frequently the focusing of their particular abilities at the patient's bed is faulty. Hence, the special skill each possesses will be of no avail to the patient unless an efficient system is devised whereby such services can be most speedily obtained and whereby each, not feeling content with his own ability, is willing and anxious to obtain the advice of another. A hospital staff composed of general practitioners cannot be highly efficient in the modern handling of disease because no attempt has been made by each individual at the acumination of skill and study in a particular aspect of illness.

There is a tendency on the part of physicians everywhere to delay calling a consultant until the condition of the patient becomes desperate. The hospital, therefore, has both a right and a duty to insist that consultations be routinely called and that these be not of the perfunctory type, consisting merely of setting down on paper an opinion that may be translated at some other time into action.

A real consultation consists of the presence about the patient's bed of two or more physicians, each of whom possesses a different viewpoint and a varying degree of diagnostic acuity and skill. A consultation, to be of the greatest value to the patient, is not always one in which there is a ready and quick agreement as to the nature of the illness and the course to be pursued. An internist who too quickly, in an elective case, is willing to consent to radical surgery and a surgeon who believes that conservatism is rarely a virtue are not likely, in consultation, to consider cautiously every angle of the patient's condition.

A skillful hospital administration will construct among members of a staff, be it large or small, a smoothly running liaison from which there will come a consensus not only as to the nature of the patient's disease but also as to the manner in which it shall be attacked. Procrastinations, inability to secure specialty opinions quickly, shoddy recording of consultation records, all spell disaster to the patient.

To be sure, each staff clinical-pathological conference is, in a measure, a consultation. But these do not materially assist the living except in an indirect way by providing greater individual and group skill in the handling of future patients. The making of rounds by division heads and their staffs may be termed intradepartmental consultations but the routine reviewing of diagnoses and the results of treatment by departmental groups cannot replace extradepartmental consultations to which members of other staffs are invited. A medical patient may rapidly assume characteristics of a surgical patient and vice versa. If only one viewpoint is obtained, as is the case in intradepartmental consultations, conservatism and self-satisfaction, which are likely to give rise to procrastination, may unfavorably affect the cause of the patient being studied. However, if in addition to the intradepartmental group there is found a surgeon, a laboratorian, a metabolist or an endocrinologist, the general good to the patient will be greatly increased by such a well-rounded discussion.

It is the custom in many institutions for a staff group to conduct weekly rounds. But it is often a long distance, administratively at least, between the surgical and medical wards, two of the main divisions of the hospital. Internists and surgeons may meet socially but too rarely do they walk their own wards together.

In some hospitals no surgical patient is permitted to undergo a major operation until he has been examined by an internist. The surgeon sometimes objects to such a rule because he considers it an interference in his work and a method of robbing him of his traditional prerogative to decide what is best for his patient. But

there is much to be gained by such a practice. It has been estimated by those who are well informed that a patient admitted to a surgical ward with a surgical diagnostic tag attached runs a far greater chance of having radical procedures performed upon him than one who is admitted as a sick man with no preconceived ideas as to his diagnosis.

If it were possible for all patients to be admitted with an open diagnosis and then carefully studied by internists, surgeons and other specialists, it is conceivable that the resulting cloak of conservatism thrown about the patients might prevent dangerous and hasty radicalism. Of course, there are many types of surgical and medical conditions in which the treatment indicated is perfectly plain. However, in many types of subacute or chronic illnesses it cannot be immediately ascertained whether drugs or surgery offers the greater hope of cure.

When Nonstaff Men Are Consulted

When patients are admitted to an open hospital ward they sometimes request consultations from those outside the regularly appointed staff. This presents a difficult problem. If, as is usually the case, staff physicians are carefully selected, are attentive to their duties and are capable of estimating closely the type of ailment present, it would seem unfair for the institution to permit another who knows less about the patient to be called and to receive a fee therefor. However, it should be always permissible for a staff man to call a member of the consulting group if and when he believes such an action to be to the best interest of the patient. It would be patently unfair for a staff man conducting a busy ward service without recompense to be forced to call a nonstaff physician to see a ward patient and have the latter be paid for his advice.

There is another angle of this problem. In some hospitals, staffs insist that all consultations on private patients must be restricted to members of the regularly appointed group and that outside physicians cannot be called as consultants. Since the same staff men are expected to respond promptly and without charge to ward consultation requests, they contend they should be called for consultation for which they may charge a fee. But the rule should exist that the best interests of the patient must be served no matter who is called. Moreover, the family should have the right to request a consultant provided he be mature, well trained and of equal ethical and medical rank with the physician in charge of the case. Members of the cults, of course, should never be permitted to enter a recognized hospital as consultants.

The private patient is in somewhat of a plight because usually he has no access to the opinions of other physicians in the hospital unless they are invited by his own attending physician. It is difficult to open the door of the private room to a consultant whose advice may be urgently needed although neither the patient nor his relatives are convinced of this fact. But it is precisely this which the rules of the hospital should ensure.

In the maternity department, it is a good rule to insist routinely that every member of the junior and courtesy staffs who has a patient in labor longer than eighteen hours shall call a consultant. This service may be obtained for the patient free of charge. Most obstetricians and gynecologists are willing to enter into this agreement if the patient is unable to pay a consultant's fee.

Strategic Time for Consultation

Such an arrangement is more difficult in medical cases because no clear-cut dividing line can be set down as to when the consultant should be called. It has been suggested that when a critically ill notice is dispatched a consultant should be called, especially if the age and the experience of the physician in charge would indicate the wisdom of such a course. It has also been suggested that certain diseases, such as meningitis, pneumonia and typhoid fever, should be specified as conditions requiring the advice of an older and more experienced physician. None of these plans is wholly feasible. On the wards no such restrictions and rules are necessary; the foregoing suggestions concern only private and semiprivate patients.

The same problem exists in regard to surgical patients, except that in the average hospital surgical privileges are granted to a relatively small and carefully selected group. In the case of surgical patients it is a good plan to send an admission card to both a surgeon and an internist in rotation. In the children's department both the pediatrician and the surgeon should receive such a notification. If this plan is to function properly, the response to this notification must be so timed that no delay in surgical treatment will result.

Consultation requests in the case of patients of special interest or severity may be sent to the consulting physician on emergency forms, often red or orange in color, so as quickly to attract the attention of those handling them. On the medical ward all patients suffering with such conditions as typhoid fever, toxic goiter, gastric ulcer particularly of the bleeding type, gall bladder disease and malignancy should be seen by the surgeon upon their admission.

Plan for Teamwork

Another system that often works well is to request the surgical staff to assign to the medical ward a young surgeon and the medical staff to assign to the surgical ward a physician who will visit these patients daily. Good teamwork is often obtained by the development of a liaison between the metabolist and the surgeon on the diabetic cases and the cardiologist and the surgeon on thyroid cases. When the patient's chart is compiled on admission a regular consultation sheet may be added containing the name of the surgeon expected to visit the medical ward or of the internist expected to visit the surgical ward. The consultant should be expected to revisit the patient until the condition interesting him has been relieved.

It would be a splendid thing for the patient if the medical consultant could be seen more often in the operating room. It is encouraging to note, in teaching institutions particularly, the continuous use of a graphically displayed electrocardiograph during thyroid operations.

No matter how fine a hospital staff, how skilled its individual members, how smoothly working each department, unless the administrator works out methods by which the members of this staff can be geared together to the best interest of the individual patient, a fine opportunity for the shortening of illness and the saving of life has been overlooked.

"R.N.—*Serving All Mankind*"

SCENES from the new film produced by the American College of Surgeons to spur the enrollment of student nurses. Premières are being held this month and copies of the film, in both 16 and 35 mm. sizes, will be available soon for showing by hospitals, theaters and schools to young women of high school and college ages. The film takes 22 minutes to show.

Right: Using one another as patients, the girls learn to take blood pressure. Below: Joan at work on a serious problem in the chemistry laboratory.

Right hand column, top to bottom: A group of student nurses studies the skeleton; Merrily, one of the principal characters in the new film, preens before a mirror after the capping ceremony; bedside care is part of every nurse's training. Below: Graduated and assigned to serve with the U. S. armed forces.

ENTRANCE TESTS

Can be practical and become a significant factor in evaluating candidates for a stable, alert and enthusiastic student personnel for the school of nursing

BESS L. McCLANAHAN

TULSA, OKLA.

TO DEVISE a procedure by which capable and adaptable candidates for nursing education may be selected with reasonable confidence and assurance of success is a problem of major importance to schools of nursing. The problem is twofold: academic and practical.

Previous research reveals comparatively little experimental work done with standardized tests in the field of nursing education. As part of a research study of 3500 professional women, Miles[1] found the average I.Q. of 78 nurses in training to be 118. Bregman[2] studied 10,000 student nurses and reported the average student nurse outranked by the average college student; only a few of them scored at the higher levels.

Williamson et al.,[3] using a large battery of tests, tested the students in more than 20 private schools of nursing in Minnesota (1934-37). The tests were given at the beginning of the school year and the results were correlated with their subject marks at the close of the year and with a specially constructed objective test covering the subjects of instruction. Although the coefficients of correlation were generally disappointing, those for the science courses yielded the highest results and those for the practical nursing courses, the lowest, probably due, as suggested by the investigators, to the more objective character of science subjects. No significant difference was found between the ability and variability of the eliminated and selected students. The assumption was made that tests could be used to greater advantage if instructors' marks were more reliable.

Two other investigators, South and Clark,[4] tested 68 student nurses with a large battery of tests two weeks after entrance. Before the preliminary period was completed, more than 14 per cent of the group had been eliminated. Inasmuch as a considerable number of students in unselected groups usually withdraw within the first two weeks, the percentage of eliminations for the whole preliminary period was very likely greater. The investigators recommend the use of standardized tests in the selection of applicants for nursing education, but they advise the use of a few well-adapted tests rather than a large number of tests.

The present study was begun in the Morningside (now Hillcrest Memorial) Hospital School of Nursing, Tulsa, Okla., in August 1938. The data were derived principally from two sources: (1) scores from standardized tests administered to preliminary nursing students and (2) first semester theoretical or subject marks for the same nursing students.

In an effort to determine the potential scholastic ability of the students, two tests were used: the Ohio University Psychological Test, Form 19, and the Iowa Silent Reading Test, Advanced Form. These tests were administered to six preliminary groups in Morningside (1938, 1939 and 1940) and to the preliminary groups in 11 of the 12 other nursing schools of the state in 1939.

The first three groups of Morningside were accepted without discrimination. After analysis of their data, a requirement was set below which, except in cases seeming to possess strong practical nursing qualities and a determination to succeed, applicants were not accepted. The practice of examining applicants some time in advance of entrance was also adopted. Beginning several weeks before enrollment, examinations, including physical, were given at specified dates. This method proved valuable in securing a more select group, which gave a greater guarantee of student tenure.

For purposes of comparison, the test scores were transmuted into percentile ranks based upon the norms of the particular tests used in rating the students.

After analysis of the entrance test scores and the first semester theoretical marks for the three unselected groups, an average percentile rank of 20 was established as a minimum standard requirement for enrollment in the Morningside school. The average percentile rank was determined by averaging the percentile ranks for total reading comprehension and the students' psychological scores.

The entrance data for Morningside for the three years revealed two things: (1) the consistent and progressive rise in the median percentile ranks for the reading scores and for the psychological scores, (2) the relatively lower percentile ranks for

[1]Miles, Catherine Cox: Personality Development of Student Nurses, Am. J. Nurs., Feb. 1934.

[2]Bregman, Elsie O.: The Performance of Student Nurses on Tests of Intelligence, Nurs. Ed. Bul., New Series, II, March 1933.

[3]Williamson, E. G., Stover, R. D., and Fiss, G. D.: Selection of Student Nurses, J. Ap. Psych. **22**; No. 2, (April) 1938.

[4]South, Earl B., and Clark, Genevieve: Some Uses of Psychological Tests, Am. J. Nurs., Dec. 1929.

the psychological scores, which was also true of the other schools of the state.

In 1938 only 12.8 per cent of the students admitted into the Morningside school ranked above the median expectancy for college freshmen; in 1939, 40 per cent; in 1940, 53 per cent. The other schools of the state struck a median of 32.6 per cent. It should be recalled that the data for those schools were only for the students admitted in the summer and fall of 1939.

First semester eliminations for Morningside were reduced from 25 per cent in 1938 to 7.7 per cent in 1940. Several of the other schools of the state reported an approximate 25 per cent first semester student turnover in 1939. So great a turnover is uneconomical from both the standpoint of service and that of the disruptive effect upon the morale of the student personnel.

The test scores and the first semester theoretical marks (teachers' marks) yielded a satisfactory correlation coefficient[5] of .58 for Morningside and .40 for all schools, including Morningside. Here, again, the effects of incomplete data for eliminated students may have tended to diminish the degree of relationship between entrance test scores and theoretical marks.

PERCENTAGE OF MORNINGSIDE STUDENTS RANKING ABOVE EXPECTANCY OF COLLEGE FRESHMEN

Year	No.	Reading Ability Per Cent	Potential Academic Ability Per Cent
1938	31	38.7	6.4
1939	25	48.0	20.0
1940	30	76.6	43.3
	OTHER SCHOOLS		
1939	144	44.0	19.0

As revealed by the tests, the reading ability of the students far exceeded their potential academic ability as indicated by the psychological test scores. The accompanying table shows the number of students admitted each year and the percentage of students ranking above the medians for reading ability and potential academic ability expected of college freshmen.

Assuming the reliability of our tests, the data obtained from the psychological test reveal that student nurses in general in Oklahoma rank below college freshmen insofar as potential academic ability is concerned. And this lower psychological ranking may reflect a lack of emphasis in the development of reasoning power in the earlier education of the students.

A comparison of the data for eliminated and retained students revealed that eliminated students tend to have a lower average of scholastic ability and a greater variability than retained students. The data for the other schools of the state, however, showed comparatively the same medians for eliminated and retained students. This result can be explained, partially at least, by the fact that the tests were given in those schools some time after enrollment of the students and the chances are great that a considerable number had already been eliminated before the tests were given.

The distributions of data significantly revealed that the spread for the theoretical marks was definitely less than the spread for the entrance test scores. The distributions of both kinds of data were skewed but in opposite directions: theoretical marks tended to pile up at the high end of the scale and entrance test scores tended to pile up at the low end of the scale. Teachers had given a disproportionate number of high marks and students were generally of a lower academic ability.

On the basis of the data utilized in this study, the following conclusions are made: (1) there is a positive relationship between the test results of the particular tests used and the theoretical marks reported by teachers; (2) a higher median of potential scholastic ability results, in general, in a higher average of theoretical performance; (3) eliminated students tend to have a lower average of scholastic ability and a greater variability than retained students; (4) careful selection of candidates for nursing education reduces student turnover.

[5]Ross, C. C.: Measurement in Today's Schools.

The unreliability of theoretical marks arbitrarily assigned indicates a need for teachers to be qualified to construct and use objective tests for the purposes of measuring more accurately the outcomes of their teaching procedures and of comparing them intelligently with the needs of their students and with the aims and objectives of the nursing curriculum.

A closer coordination between schools of nursing and secondary schools and colleges should result in better adaptations of nursing students not only in respect to academic prerequisites but in personality prerequisites and a better understanding by the student of the requirements of the profession.

Valid and reliable standardized tests are available for testing potential scholastic ability and are to be recommended for use in selecting student nurses. But a note of warning should be sounded in the use of personality tests for the same purpose.

Mrs. R. Louise McManus, research assistant of Columbia University and chairman of the National League of Nursing Education's test committee, in a personal letter has expressed the consensus of able educators regarding the use of personality tests in the selection of students. She says: "In addition to intellectual capacity, the personality traits of the individual must be considered in the selection of applicants into schools of nursing, yet in this area we do not have very valid objective means of evaluation.

"Most of the standard instruments for measuring personality traits have been developed as guidance tools and require the fullest cooperation of the student being guided — cooperation that results from an understanding that the purpose of the test is to help her learn something about herself and to help others help her. When these instruments are used in the selective process, the student feels that something is being done to her rather than for her, that she will be accepted or rejected on the basis of her responses; hence, she will tend to answer each question in terms of what she thinks the school wants or what she thinks is the best answer rather than what she really feels. . . . Hence, her answers give a picture that is far from her true self."

31 TRIFLES

Perfection in first impression of patients and visitors can be built on attention to good manners, small courtesies and simple "dont's" for the front office, as suggested here

JOHN McSWEENEY

CHIEF DESK CLERK
ST. LUKE'S HOSPITAL, CHICAGO

1. Greet people with a smile. A smile instead of a frown can do much to relieve the nervousness of excited patients and guests.

2. See that clerks and other employes, such as bell boys and doormen, are neat in appearance. Neatness gives a favorable first impression to patients and guests.

3. Have a bell boy or volunteer aide available at all times to give both incoming and outgoing patients immediate service. Instruct him to take care of all flowers, packages, mail and telegrams promptly. The clerk should supervise these boys.

4. Handle all reservations for rooms through the front office.

5. See that clerks know thoroughly all room rates, thereby eliminating delay.

6. Have clerks show all the rooms to patients when a choice is requested. Many questions arise that only the clerks can answer.

7. Require clerks to know the exact location of each room without fumbling through card files to find room numbers.

8. Explain room rates carefully.

9. Escort patients to their rooms as quickly as possible. It is a good idea to get personal information about patients in their rooms as some of them object strenuously to talking in the lobby.

10. Ascertain the diagnosis of each incoming patient. Patients who have pneumonia, upper respiratory infections and tuberculosis should have private rooms or should be accommodated together.

11. Train the clerk to know the service on which an accident case is to be entered. Quick service sometimes saves a life.

12. Keep wheel chairs on hand at all times.

13. Notify the nurses when ambulance cases are coming in. It is necessary to have rooms ready for such patients.

14. Make every effort to accommodate patients when the house is full, but failing to do this immediately assure the doctor that his patient will be taken care of at the first possible opportunity.

15. Train the clerk to know all of the staff men, the service to which they are assigned and the difent floors to which their patients go. Many a discussion is avoided if the clerk does not have to look up these things.

16. Exercise the utmost care when talking over the operating schedule with doctors. In most hospitals there is a limited number of operating rooms for a large attending staff. By knowing the approximate length of time needed for each operation, faster service can be rendered the surgeons.

17. Expect all clerks to know the doctors' office hours, the location of their offices, the time they are usually in the hospital, whether or not they are operating and, if they are not in the hospital, when they will be there.

18. Expect clerks to know the location of surgical supply houses, other hospitals and serum centers. It is surprising how many inquiries a hospital has about these places.

19. Require clerks to know the location of ambulance companies. Delay on the part of the clerk in calling for an ambulance to go to a particular district may be disastrous.

20. Train clerks to answer courteously requests for information or help from outside firms, such as undertakers, police and industrial concerns. Good service helps create good will for the hospital.

21. Expect them to have information about places of interest in the city and about the various forms of transportation.

22. Take immediate care of persons asking questions; answer them clearly and pleasantly.

23. Keep the information desk clean at all times.

24. See that supplies are on hand at all times. This should be one person's duty. Shortage of supplies sometimes results in poor service for the patient.

25. See that telephones are answered promptly. One ring by the operator should be sufficient; too many rings disturb patients and visitors who may be standing in the office.

26. Expect the clerk to know the working time of all employes. Many times there is a conflict in the working hours of employes over whom the clerk has jurisdiction.

27. See that clerks take care immediately of needed repairs reported to the office. Instruct them to write down, rather than attempt to memorize, orders for repairs or for services of any kind.

28. Train clerks to be helpful to the patient and to the cashier by accepting money or checks instead of having patients wait at a crowded cashier's window.

29. Ask clerks to see to it that employes, interns and doctors do not congregate or linger long around the front office because of the poor effect this practice has on visitors and guests.

30. Prohibit smoking and loud talking on the premises.

31. See that all complaints coming through the front office are reported to the chief clerk. If he cannot satisfy the complainant, the matter should be referred to the director or to his assistant.

"Passed by the Censor"

Interpreting Hospital Ethics

S. R. SPELLER, LL.B.
EDITOR, THE HOSPITAL

London, England
Aug. 15, 1942

DEAR Colleagues in America:

I have recently received from at least four sources copies of the Code of Hospital Ethics drawn up by the joint committee on ethics of the American Hospital Association and the American College of Hospital Administrators, a code also approved by the Canadian Hospital Council. I could not but be struck, therefore, by the importance which your hospitals and hospital administrators throughout the North American continent attach to the publication, and I have read it with the keenest interest and with a view to noting differences of outlook, if any, between you in America and us in Great Britain. I was looking for differences, not critically, but with the intention of ascertaining whether your code of ethics contained anything which we had not yet grasped and also whether the code pointed to any fundamental differences in hospital organization.

The thing which impressed itself on me most forcibly was not differences in principle and practice, but the difference in outlook. You in North America whether in the United States or in Canada have lived your lives under a written constitution whilst we over here, as you know, have no basic written constitution, parliament being free to change even the most fundamental laws without any special formalities or safeguards. When I see the ease with which dictators can arise both in countries with a written and an unwritten constitution I do not think the safeguards to our liberties lie in one direction or the other but in the will of the people to be free.

Your code, however, clearly reflects the written constitution of your two great countries, for you have taken care to reduce to writing many basic principles which although not written have no doubt governed the work of your hospitals and of your administrators as they have ours for many years. I allude particularly to such statements as the following:

"Appointments should be made on a basis of merit and not because of political connection or favoritism. . . . No member of the board should expect to profit by his connection with the hospital. . . . The utmost care must be exercised to ensure that the welfare of the patient is entrusted only to conscientious, sober and faithful physicians of upright character, sound morals and good reputation."

I believe that the inclusion of these points in your code might mislead some people over here; because you mention them in your code they might believe that your hospitals were more afflicted than ours with the evils pilloried. On the other hand, if any similar code were drawn up over here, such points would probably be omitted as taken for granted; therefore, hospital people on your side might stigmatize us as a hopelessly immoral lot since silence might be interpreted as approval of obvious malpractice. I am persuaded that for the greatest mutual understanding between our peoples such differences of outlook should be brought to light and put in true perspective.

Certain practical differences between your hospital system and ours are suggested by your code, such as by the statement: "There should be no solicitation for patients by a hospital or by any person connected with it. . . . Information relative to the activities of a hospital should not be designed to secure comparative advantage over other hospitals or personal aggrandizement of any individual."

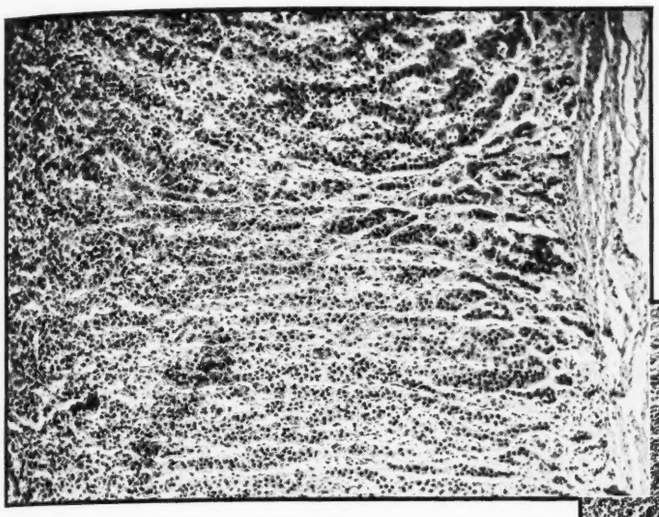
That rule suggests to me the point that, for all but indigent patients, your hospitals reckon to work on a business footing and to show a satisfactory balance sheet at the end of the year. That being so, it is understandable that there are to be rules insisting on fair competition. But in England the voluntary hospitals are in the main for the treatment of persons who cannot afford full costs, the pay patient blocks being a comparatively recent development. Indeed, there are not sufficient pay-beds available in this country for all who desire to make use of them, furthermore, the aim of practically all hospitals is to work even those beds on the narrowest possible margin of profit, this in the interests of the middle and lower-middle income groups. The wealthier members of the community are only now just beginning to realize the great advantages of the pay-bed block of a hospital over any but the most expensive and elaborate nursing home.

To complete the picture I would add that the local authority hospitals established under the Public Health Act already provide the majority of hospital beds in this country, hardly any providing private patient facilities, that being contrary to the spirit of the act under which they were founded. Consequently, any member of the community, rich or poor, has the right to enter the general wards of one of these hospitals, the charges being assessed according to the patient's need but in no case exceeding the average bare cost of maintenance and treatment per patient for the preceding year, usually some £4 or £5 (say $16 to $20 per week). Thus you will see those parts of your code of ethics touching on competition would be irrelevant over here.

In other respects your code serves to illustrate how closely your problems approximate our own. The recommendation that there should be close cooperation amongst hospitals and how these recommendations could be implemented are much on the lines of what we are thinking and doing over here. Also, the British Hospitals Association, in conjunction with the representatives of the leading contributory schemes over here, is doing its best to discourage contracts for hospital service at cut rates (your clause 10).

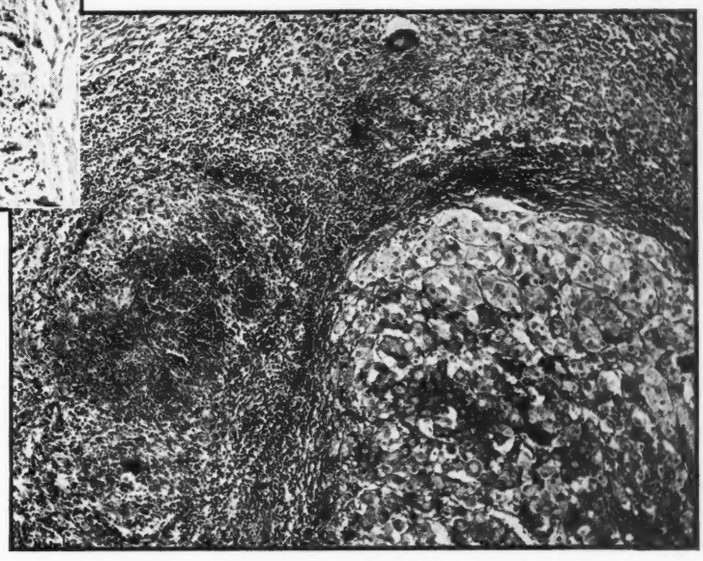
As to the question of religious and moral codes, over here we have few hospitals under the direct control of a particular church organization and, happily, difficulties do not seem to arise frequently, but when they do they are of a distressing nature. Most of the larger voluntary hospitals, if they appoint a whole-time chaplain, tend to appoint a minister of the Church of England, but I should say that in all cases full facilities are given to chaplains nominated by the Roman Catholic Church and by the Free Churches, *i.e.* Christian denominations other than the Anglican and Roman communions.

ADRENAL CORTICAL STEROIDS ESSENTIAL TO LIFE



Tuberculosis of the Adrenal

The original description of Addison's disease attributed the condition to tuberculosis of the adrenal. Recent autopsy series show that there may be other causes and that these account for a considerable proportion of the cases.



Normal Adrenal Cortex

The cortex of the adrenal gland is essential for life in human beings and in all animals which possess this gland. Its removal is fatal within a few days.

Sterile Solution Adrenal Cortex Extract (Upjohn)

Sterile Solution Adrenal Cortex Extract (Upjohn) is an extract of adrenal glands from domestic animals, containing the cortical steroids essential for the maintenance of life in adrenalectomized animals, but so purified that only traces, at the most, of epinephrine are present. Each cc. contains not less than 50 dog units of cortical activity (2.5 rat units) when assayed by the method of Cartland and Kuizenga (American Journal of Physiology 117:678, 1936).

Sterile Solution Adrenal Cortex (Upjohn) is of value in cases of Addison's disease or of adrenal cortex insufficiency, and in surgical procedures involving the adrenal gland, such as removal of cortical tumors, as a prophylactic measure to prevent the development of symptoms of adrenal cortex insufficiency.

Sterile Solution Adrenal Cortex (Upjohn) is supplied in 10 cc. size rubber-capped vials as a sterile solution for injection.

THE UPJOHN COMPANY · *Kalamazoo, Michigan*

Fine Pharmaceuticals Since 1886

Smoking Ban Lifted in Most of These Small Hospitals

HOSPITALS, like most other agencies, are rapidly adjusting their rules and regulations to the habits of the people. The attitude of small hospitals toward smoking is an indication of this social evolution. Twenty years ago even the colleges usually forbade smoking by women in the dormitories and in all other places on the campus. The rules were liberalized or relaxed (depending upon your point of view) earlier in the colleges than in the hospitals. But now the hospitals have followed suit.

Twenty small hospitals replied to a questionnaire from The MODERN HOSPITAL on the subject of smoking. These hospitals ranged in capacity from 40 to 150 beds and are located in the states of Vermont, Rhode Island, Maine, Missouri, Mississippi, Wisconsin, New York, Washington, South Dakota, Pennsylvania, Nebraska, West Virginia, Oregon, North Carolina, Ohio and Kansas.

Student May Not Smoke on Duty

None of the hospitals permits student nurses to smoke in the hospital proper but 14 permit them to smoke in nurses' homes. One hospital is debating this question at the present moment; three prohibit smoking in the nurses' homes. One superintendent whose hospital is in the latter group, however, thinks it would be better if the student nurses were allowed to smoke in the nurses' home. Three hospitals reported that the question is not applicable because they have no nursing school.

The restrictions on smoking by student nurses were reported as follows: five limit smoking to certain designated areas in the nurses' home; one provides ash trays and warns the students not to throw matches and cigarets in wastebaskets; one requires the students to provide their own ash trays and to empty them in the incinerators; two restrict the amount of smoking by young nurses, and one requires students who wish to smoke to first obtain consent of their parents.

R. Z. Deeny of the Shelton General Hospital, Shelton, Wash., (54 beds and 14 bassinets) says: "We do not have students. Our graduates have the use of the nurses' home for smoking or other recreation. There is a much better attitude on the part of the nurse if she is treated like other people."

Sixteen of the hospitals permit patients to smoke, three do not permit them and one leaves the answer up to the nursing supervisor on the floor, apparently without any particular rule to follow. One of the three hospitals that prohibits smoking by patients adds "if the patients can withhold the desire to smoke."

How Fire Hazard Is Handled

On the question of fire hazards, three hospital administrators stated that they thought the danger was much exaggerated. Two permit smoking only when someone else is present. Three permit it if the patient is rational, has ash trays and is under supervision. Two restrict smoking only to those who are sane and awake. Two mention that it is forbidden when inflammable materials are being used (presumably all hospitals would make this restriction). Two others do not permit smoking at night (after 9 p.m.).

In order to prevent smoke annoying other patients, various steps are suggested. Three hospitals attempt to classify the patients on the wards so that smokers and nonsmokers are not together. Three mention that other patients seldom (or never) seem to object. Four specify that smoking is prohibited if it annoys other patients. One hospital allows smoking only for one hour after each meal and one half hour before bedtime. One attempts to discourage smoking but does not prohibit it. One hospital administrator states that "a patient may doze off to sleep with a lighted cigar or cigaret; some patients smoke themselves to sleep." (Dr. L. M. Tillman, Wheatley-Provident Hospital, Kansas City, Mo., 67 beds.)

Dr. B. B. Martin of Vicksburg Infirmary, Vicksburg, Miss., (55 beds) states that "patients should not be allowed to smoke to excess in a hospital at any time."

"It would be impossible to prevent an inveterate smoker, scheduled for a lengthy stay, from smoking," states Millia A. Jacobson, St. Luke's Hospital, Milwaukee (102 beds and 33 bassinets).

Sister Mary Martena of Mercy Hospital, Scranton, Pa., (104 beds) suggests that "very ill patients must have a nurse or responsible relative with them while smoking."

Two hospitals prohibit smoking in semiprivate rooms and wards but permit it in private rooms.

Staff Rules Enforced

Smoking by the members of the medical staff is the most difficult to control. All of the hospitals permit staff doctors to smoke in the doctors' dressing rooms; 11 hospitals permit and nine prohibit them to smoke in corridors and public places; all of them seem to prohibit doctors from smoking in the patients' rooms or while examining and treating patients.

"Enforcement of staff smoking rules is difficult but can be controlled if left in their hands with a committee to assist," states Dr. Francis J. Bean of Putnam Memorial Hospital, Bennington, Vt., (125 beds).

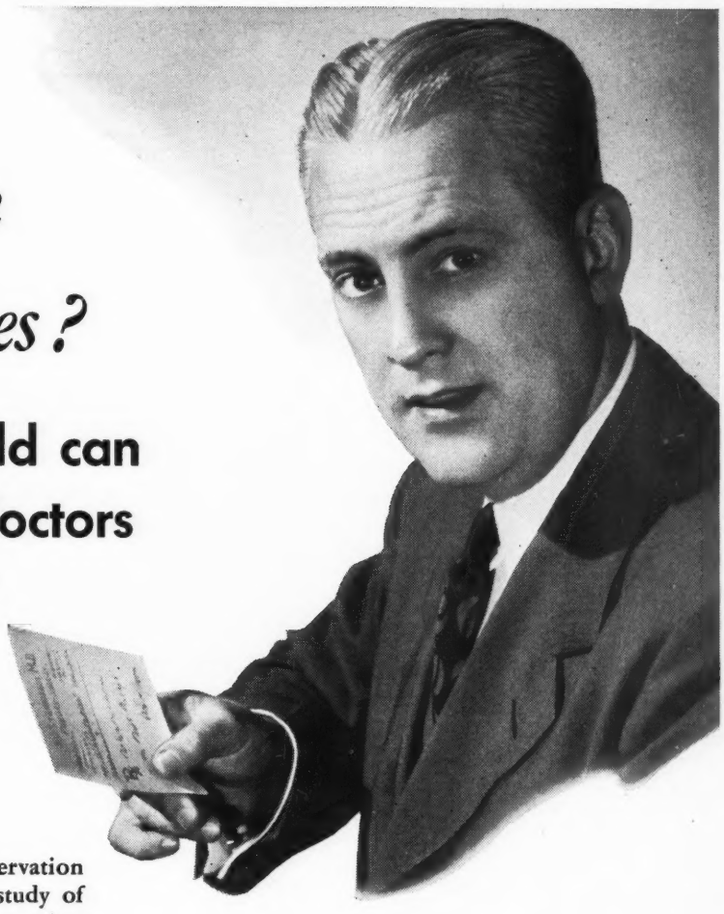
"The doctors are the worst offenders and it makes it hard to prevent smoking by patients," reports Helen M. Blaisdell, Westerly Hospital, Westerly, R. I., (85 beds).

"Doctors should be allowed to smoke in doctors' dressing rooms, corridors and public places," according to Dr. B. B. Martin. "Being physicians they are naturally supposed to conduct themselves properly at all times."

"So far I have found no way to control doctors," reports Mabel

Conserve on Sutures?

How in the world can hospitals and doctors do that?



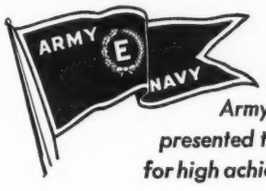
ON FIRST THOUGHT, suture conservation may sound impractical. But a careful study of your operating room procedures and operating technique may reveal important and practical answers. Suggestions have already been made to our representatives that convince us that this appeal from the Army and Navy Munitions Board is going to get action from the surgeons and hospitals of America. The appeal follows . . .

". . . This office has requested the Division of Medical Sciences of the National Research Council to formulate and promote suitable measures which would encourage conservation of sutures in domestic surgical practice. It is felt that your organization, through its advertising and sales functions, can also assist materially in such a conservation program. Therefore, this office suggests that you consider such procedures as might contribute to this end."

CLIFFORD V. MORGAN,
COL., MEDICAL CORPS,
A. N. M. B. CONTACT OFFICER,
DRUGS RESOURCES ADVISORY COMMITTEE.

While surgeons will find their own individual ways of conserving—practices best suited to the personally preferred techniques—it is hoped that they will share their experiences with others.

Suggestions reaching us through our representatives from the surgeons and hospitals of the nation will be passed on to the profession at large in the same spirit of helpfulness in which the following are submitted.



Army-Navy Production Award presented to our plant and employees for high achievement in war production.

★ ★

HOSPITALS AND SURGEONS FIND THESE CONSERVATION IDEAS PRACTICAL

To call attention dramatically to catgut waste, hang on Doctor's bulletin board all the catgut pieces left from a day's operating. The number of 60″ strands represented can be computed—will help point up your economy appeal.

Open the "last" tube when it's needed—it is appreciated that the need for saving valuable seconds during the operation prompts the suture nurse to open plenty of catgut so it will be instantly available. But many times that "last" strand isn't needed, so 60″ of catgut are thrown away. Your suture nurse can help you make economies by opening that "last" tube speedily *if* it's needed.

LEWIS MANUFACTURING CO • BAUER & BLACK • *Divisions of The Kendall Company* • *Chicago*

★ ★

Henry Mooney of the Levering Hospital, Hannibal, Mo., (150 beds).

Miss Deeny of Shelton General Hospital says that she doesn't think one can prohibit doctors from smoking and have a satisfied staff.

Sister Mary Martena says that her doctors "smoke everywhere and at all times, except in operating and delivery rooms."

"No hospital has any right to set up rules and regulations to interfere with personal privileges," according to J. G. Kitzelman of the Lutheran Hospital, Beatrice, Neb., (45 beds).

In contrast to several other administrators, George L. Losh of Robinwood Hospital, Toledo, Ohio, (105 beds) states that "our physicians smoke in dressing rooms but not in corridors. They are quite cooperative and we have no problem with them."

Mother M. Alphonse of St. Joseph's Hospital, Rice Lake, Wis., (40 beds) states that doctors "should have enough respect for their own dignity to refrain from smoking in the corridors and public places. We do not have any trouble along that line."

All of the hospitals permit visitors to smoke in the waiting rooms, lounges, sun rooms and similar places. Fifteen hospitals permit and five prohibit smoking by visitors in the patients' rooms. Of the fifteen that permit this, four restrict it to private rooms and four permit it only if agreeable to the patient. Of those that prohibit smoking in patients' rooms, one admits candidly that visitors do it anyway.

Smoking in the dining rooms, although now generally permitted in restaurants and railroad dining cars, is not common in small hospitals apparently. Two of these hospitals report that they permit it generally and 13 that they generally prohibit it.

One permits smoking in the private dining room for interns and house staff and another states that a smoking room adjoins the dining room. Two say that smoking is permitted the doctors in the dining room but not the nurses "because they are in uniform." One mentions that "of all places, it is generally accepted as the most ideal for smoking after meals—or before." Two mention that they do not have any problem, one because employes eat out.

WOMEN'S SERVICE GROUPS

Pretty Place to Convalesce

Down St. Louis way everyone is very proud of the charming and pleasant Miriam Convalescent Home at Webster Groves. Mrs. Alice P. Gresham, director, has just completed her first five years at the home during which time it has been transformed from a drab establishment to a fresh pretty place in which to convalesce. Bedspreads are monogrammed, glass curtains are pink flowered dotted swiss and other dainty features not usually found in an institution that caters almost entirely to free patients are reported.

No more enthusiastic backer of Miriam Convalescent Home can be found than Florence King, administrator of Jewish Hospital, St. Louis. While entirely separate from Jewish Hospital, the hospital looks upon the home as its beloved little sister. Though organized and financed chiefly by the Jewish group, it is nonsectarian in service.

●

Now, a Bedside Film Service

Perhaps this is the time and place to tell about the Volunteer Film Association, another St. Louis asset. It was February 1939 when Medical Student Marjorie Lang and Occupational Therapist Susan Barnes discussed with friends the idea of a bedside film service. The small beginning made aroused so much interest in the homes of the sick that the girls took their idea to the Social Planning Council of St. Louis.

Now, under sponsorship of this council, 150 men and women pay $1 a year and donate a free period once a week to this work.

The association owns a few comedies but mostly it rents films or gets them free except for the mailing costs from state, federal, school and university film libraries and also large industrial concerns. Individuals sometimes lend their travel films for showing.

The Volunteer Film Association, having procured a film, previews it and then, if acceptable, routes it to the homes of patients who have been referred by nurses, social workers or occupational therapists and approved by the attending physicians. Small groups in hospitals and convalescent homes also see the films.

Not even lack of a dollar membership dues need keep an interested person from belonging to the association, for if he enlists for "behind the scenes work," such as typing, filing, routing and checking, or for volunteer exhibitor, he is considered a member.

Teams of two make the calls, so that the equipment may be handled more easily. One of these is trained in showing the movies.

We write of this plan in such detail, thinking women's service groups in the hospitals of other cities might wish to develop a similar plan. If you want more information about the St. Louis venture, write Marjorie Lang, 5965 Cabanne Place, or do a little private investigating during A.H.A. convention week.

●

Glad of Gift Shop

Those pondering the establishment of a gift shop will find encouragement from the ladies of St. Luke's, Chicago. Three years ago the woman's board opened St. Luke's Shop, locating it in the lobby of the Michigan Avenue Building.

Mrs. John W. Gary, president of the woman's board, now proudly reports that the shop has made a 14.28 per cent return on the original investment, not including $600 deposited in the sinking fund for depreciation. From last year's profits $1000 was turned over to the hospital to be used for the care of indigent patients.

●

Has Biggest Year

St. Luke's women helpers have been active since 1864, with 1941 setting a record of achievement, we learn from Mrs. Gary's recently issued annual report. Board members personally paid or pledged $164,570 for the new nurses' home and through their efforts additional funds were raised. Much of the credit for the refinements in plans for the home and for details of furnishings goes to the woman's board committee, which has worked closely with the architect.

Wishing to have a part in St. Luke's Employe Health Service started last year, the women agreed to pay the salary of a nurse for this service until Dec. 31, 1942.

This ambitious group raises most of its funds through its far-famed fashion show, the fifteenth edition of which was held last winter, netting $31,549.07. All told, these shows have cleared close to half a million dollars and have helped, in no small measure, to carry St. Luke's charity load.

England Has a Plan

For many years England has recognized the need for coordinating hospital services in which the best features of the voluntary system would be retained and integrated with public health and other public medical services. Its efforts in this direction, including the organization of the Nuffield Provincial Hospitals Trust, while not presuming to establish any future pattern, are significant as indicative of the attention that one nation is bestowing upon hospital problems at this critical time

NOT ONLY will there always be an England, but from the ruins of its war-swept countryside will rise a better England. Such national confidence and determination are manifest despite three years of war. It has taken definite form in postwar plans for housing, public health, education and hospitals.

Before the war even, England recognized certain defects and inefficiencies in its hospital system and took steps to rectify them. In 1937 the report of the Sankey Commission was published with the recommendation that voluntary hospital services should be placed on a regional basis in order to obtain greater efficiency and economy. Efforts were taken to establish closer coordination between voluntary and municipal hospitals to assure fuller use of existing resources. No longer could the voluntary hospital be expected to carry the whole burden.

Significant are some of the points covered by Viscount Sankey at that time. He made it clear that he was not in any way reflecting upon governmentally provided services staffed by men and women of equal ability and enthusiasm and with an equal desire to benefit the patient. But there was a distinction between the state and voluntary system in this respect, he said—the voluntary system had more freedom and more elasticity. It was able to make more experiments and to do things that the more rigid rules quite rightly imposed by governmental control upon the state service prevent. Too much regimentation should be avoided. On the other hand, there was no disposition to discourage local patriotism.

At the same time that it enumerated the advantages of the voluntary hospital system, the Sankey report pointed to its disadvantages. More than anything else it lacked coordination and supervision.

In the year 1939, through the generosity and vision of Lord Nuffield, there was founded the Nuffield Provincial Hospitals Trust which, following through on the Sankey report, sought to promote a general scheme of hospital regionalization throughout the provinces of England, Scotland and northern Ireland. Its objective is a full coordination of existing medical services within each regional area, such coordination to include the Ministry of Health, the public health authorities and the voluntary hospitals. Although the system is under the guidance of the ministry, it is set up on the basis of local self-government, permitting retention of the best features of the old voluntary system.

The trust is administered by a board of trustees comprising men and women who are actively identified with voluntary hospitals, medical organizations and local authorities in the various provinces. Its objects are twofold: to encourage the organization of regional and divisional hospital councils and, where necessary, to assist in their formation by making the necessary contributions. The trustees are also authorized to make grants and donations to hospitals through approved regional and divisional hospital councils. They do not, however, make these grants or donations to individual hospitals other than through these councils.

In effect, therefore, the trust assists in the development of proposals which, in their full application, will lead to the creation of a coordinated and effective national hospital service. It should be noted that the trust does not undertake the coordination of hospitals in particular areas, that being the task of the hospitals and public authorities themselves, but encourages and supports that work whenever invited to do so.

The principal administrative organ of the trust is its regionalization council. Its membership comprises men of wide experience in both voluntary hospital and local government matters. Its help and advice are at

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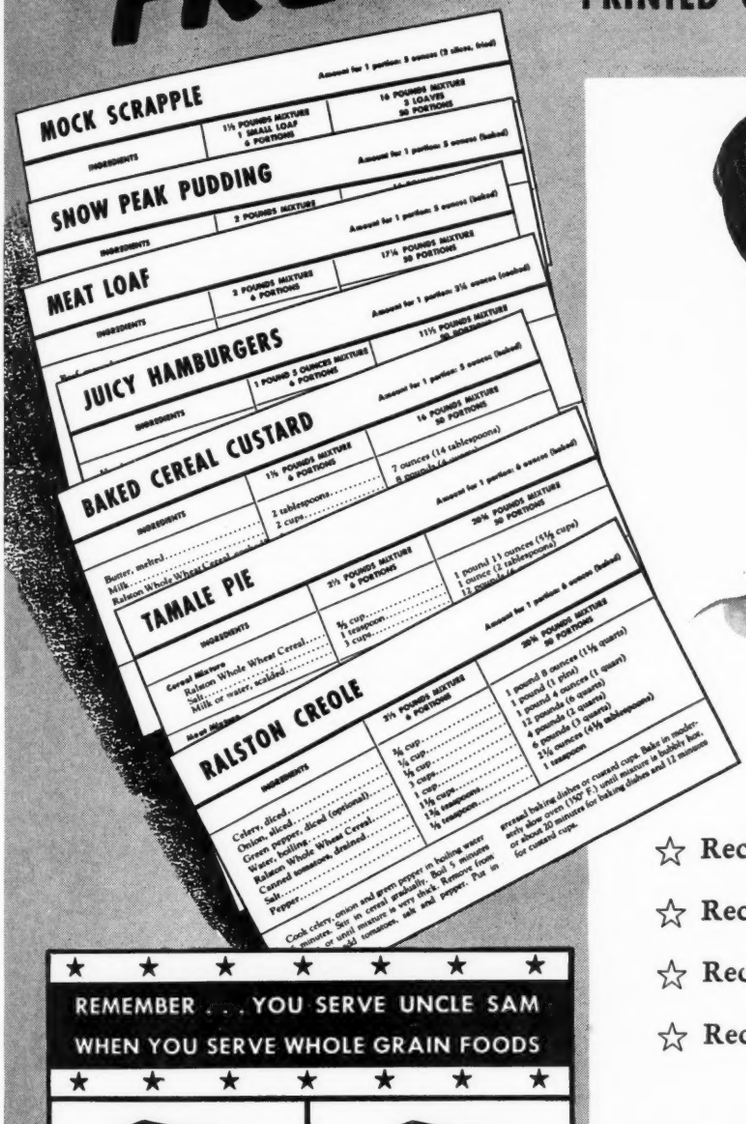

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the disposal of any region, division, voluntary hospital or local authority. When financial aid is needed to establish a regional organization (or for certain other purposes), the council makes appropriate recommendations to the trustees, but it does not intervene in the internal administration of regional or divisional councils.

It was recognized at the start that administrative reconstruction would not be sufficient. The ultimate problem of the hospital service, even when properly organized with every hospital working in full cooperation with its neighbors, must be concerned with the treatment of the sick, essentially a medical problem. So the trustees of the Nuffield Trust set up a medical advisory council comprising representative leaders of the medical profession. This council is in touch with the medical faculties and public medical officers in all the chief centers of population. Furthermore, in every region it is the purpose to set up a regional medical advisory committee that will maintain contact with the council.

The functions of the medical advisory council include: (1) receiving and reporting on questions referred to the council by the trustees or by the provincial hospital regionalization council; (2) arranging for the inspection of medical services obtaining in a region or division at the request of the trustees or of the provincial hospitals' regionalization council and to report to the appropriate body; (3) communicating directly to the trustees any expression of opinion formed by the council on matters of medical policy and interest insofar as they concern the actions and purposes of the trust.

The regionalization council also works closely with the British Hospital Association, the latter nominating representatives to the regionalization council of the trust. However, it is clearly emphasized that there is no intention that the new regional organizations should supersede the British Hospitals Association regional councils. It is appreciated more than ever before that the voluntary hospitals should have their own central and local representative bodies.

Conditions arising out of the war have necessarily affected the activities of the trust. In some areas war conditions have made it impossible to organize conferences and in others there has been some disinclination to proceed actively with the coordination of hospital services during the war period. However, there has been in many provincial areas a realization that economic conditions and service requirements are undergoing considerable transition as a result of the war and this has stimulated interest in the plan.

The conclusions as embodied in a statement of the trust are enlightening:

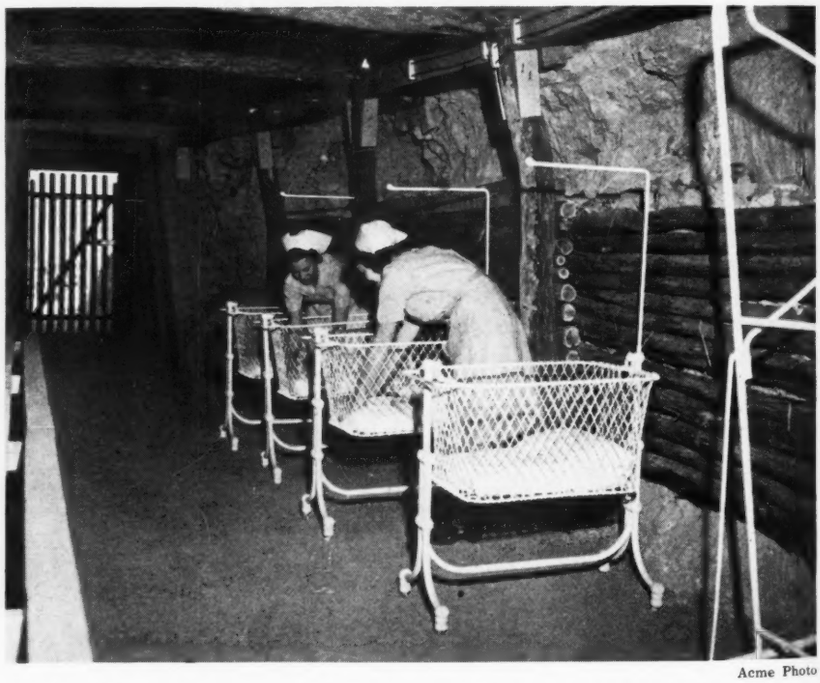
"1. The abolition of the voluntary system and the substitution of state hospitals will inevitably result in the disappearance of voluntary contributions that hitherto have amounted to several million pounds' sterling each year and will impose upon the exchequer a colossal expenditure of public funds, both capital and recurring.

"2. The Local Government Act of 1929 provided for consultation between local authorities and voluntary hospitals in regard to the provision of hospital services and the desirability of a hospital service based on cooperation between the state, local authorities and voluntary hospitals is being increasingly recognized. War conditions have emphasized the need for the coordination of hospital services along these very lines.

"3. The full implementation of the hospitals coordination scheme will produce an effective national hospital system that will coordinate the municipal and voluntary hospital services. Overlapping and duplication of services will be prevented, the most effective usage of available accommodation will be obtained and the development of new services will be undertaken only after full consultation among all the interests concerned. The coordination scheme should result in real economies in expenditure on hospital services, both municipal and voluntary, through cooperative action.

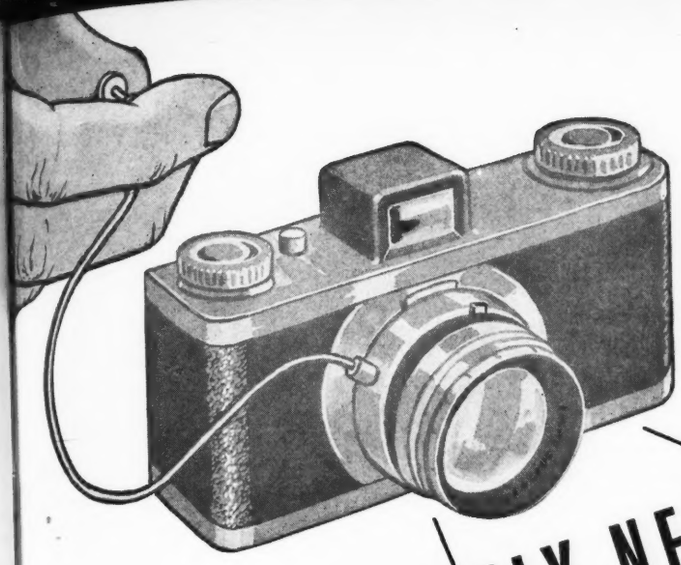
"4. These proposals will substitute cooperation for competition, provide coordination as an alternative to the continued segregation of the two forms of hospital service and produce a balanced relationship between the state, the local authorities and voluntary hospital organizations in the provision of an adequate and efficient community service.

Australian Hospital Shelter



Acme Photo

Thirty feet below ground "somewhere in Australia," 40 hospital patients can be cared for adequately. The picture above shows four bassinets, which are an important part of the maternity ward. The underground hospital also has facilities for handling emergency operations. Heavy timber used to construct the shelter is impervious to termite attacks.



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VIGILANCE Is the Enemy of Fire

ROBERT B. LLOYD
TEACHERS COLLEGE, COLUMBIA UNIVERSITY, NEW YORK CITY

THERE is no such thing as a fireproof or explosion-proof hospital. The use of fire resistive materials in new buildings ensures to a degree against the rapid spread of fire, but as long as nonresistive materials—in fact, highly inflammable and combustible materials—are used in the institutions the danger of a disaster of more or less serious consequence is always present.

Fire hazards in hospitals may be grouped under two main classifications: the commoner variety, which might even be found in many households, such as those resulting from heating, lighting, generation of power, cooking and other general operation and maintenance, and those resulting from the more specialized and peculiar functioning of institutions of which the public has little knowledge.

A check list of precautions against these two types of hazards follows.

Heating Equipment

1. House boiler rooms in separate buildings, wherever possible. ☐
2. Clean breaching, flues and stacks once a year. ☐
3. Keep oily rags and waste in metal containers. ☐
4. Keep boiler, engine and fan rooms free from dirt, dust and rubbish; scrub and mop them frequently. ☐

Electrical System

1. Have system checked by competent electricians and fire department representatives. ☐
2. Replace or correct immediately faulty switches, loose connections, damaged plugs and worn wiring. ☐
3. Wipe off electric motors where dust, lint and other particles accumulate, become oil soaked and present a fire hazard because of sparks flying from the brushes of the motor. ☐
4. Ascertain with the electrician the type and amperage of fuses to be used on the different circuits and place the responsibility definitely for their inspection and replacement. ☐

Kitchen Equipment

1. See that automatic heat controls are standard equipment on ranges, ovens, steamers, mixing machines and toasters. ☐
2. Be sure that ranges are erected on fireproof plinths. ☐
3. Clean grease ducts on ranges of accumulations of lint and grease. ☐
4. Clean hoods and exhaust flues. ☐
5. Inspect electrical connections and steam pipes routinely and not merely when they need replacement or burst. ☐
6. See that storage spaces are well ventilated. ☐
7. Use pilot lights, heat controls and other indicators, wherever possible, to signal any deviation from normal operation. ☐

Laundry

1. Never allow soiled linen to stand any length of time in huge piles or stacks. Many solutions used on patients and absorbed by the linen have combustible ingredients. ☐
2. Install pilot lights on all irons and pressing units. ☐
3. Place a protective screen around high pressure steam pipes to prevent direct contact with cloth. ☐

Paint Shop

1. Locate paint shop in separate building isolated from the hospital proper. ☐
2. Have good ventilation, safe storage containers and strict observance of "no smoking" rule. ☐

Anesthetic Agents

1. Store ether, ethyl chloride, mixtures of ether and chloroform and other highly combustible anesthetic agents in a well-ventilated room. ☐
2. See that the operating room floor is thoroughly grounded. (This may be accomplished by burying one end of a bared wire in the floor construction and soldering the other end to a water pipe or other available ground.) ☐
3. See that all motors are of explosionproof construction and all equipment is grounded. ☐
4. Require nurses and doctors to wear shoes that have conductive soles. ☐
5. Make certain that electric cord plugs are of the noncircuit-breaking type in that they have some device, such as a pin, which is inserted before the current is turned on and which cannot be removed before the current is turned off. ☐
6. Purchase equipment only after careful consideration of its construction by a competent authority. ☐
7. Have the equipment installed by persons familiar with such installations. ☐
8. Maintain the equipment carefully and constantly. ☐
9. Make frequent inspections of the humidification system and take immediate remediable measures if found not to be normal. ☐

Patients' Rooms

1. Have nurses make frequent rounds to see that no patient falls to sleep with a lighted cigaret in his fingers. ☐

HOUSEKEEPING PROCEDURES

Conducted by Alta M. LaBelle

First Chicago Institute Takes 50 Housekeepers Through Three Days of Discussion and Study

Fifty enthusiastic executive housekeepers—some of them coming from as far away as Connecticut and Texas—registered for the first Chicago institute for hospital housekeepers, held at Wesley Memorial Hospital, September 2 to 5.

Three days of intensive work and discussion of all important phases of hospital housekeeping, two evening seminars devoted to reviewing the lectures given during the general sessions and a day of field trips to hospitals kept the "students" fully occupied from Wednesday until Saturday.

Sponsored by the Chicago Hospital Council and the Chicago chapter of the National Executive Housekeepers Association, the institute covered such subjects as organization, personnel administration, budgeting, interior decoration, purchasing, rehabilitation and building programs, education, public relations and various specific housekeeping technics.

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Relation to Other Departments

The relation of the housekeeping department to other departments in the hospital was discussed from two viewpoints at the first morning session on September 2. Elizabeth W. Odell, superintendent of nurses at Evanston Hospital, Evanston, Ill., spoke for the nursing department and Harry W. Pearce, superintendent of physical plant, Chicago campus, University of Illinois, presented the viewpoint of the engineering division.

"Harmony must begin at the top, as attitudes are easily communicated," Miss Odell asserted.

Mr. Pearce pointed out that "the physical plant section is a service department and as such should assist other departments wherever possible."

•

Duties Are Threefold

Executive housekeeping—on paper at least—is on a par with all of the other departments in the hospital, asserted Joseph G. Norby, administrator, Columbia Hospital, Milwaukee, in the opening address of the housekeepers' institute. However, Mr. Norby warned, parity will be firmly established only as the housekeeping department proves its worth and the executive housekeeper demonstrates that she is the professional equal of other department heads.

The executive housekeeper, the speaker stated, must be three people in one: a manager, a supervisor and, most important, a teacher.

•

Patients Are Press Agents

"Every woman who enters the hospital, either as a patient or a visitor, is a housekeeper of some sort, and by setting an example of cleanliness and orderliness, the housekeeping department may help to improve conditions in the homes of its guests."

Thus, Mrs. Hertha McCully, executive housekeeper of Wesley Memorial Hospital, Chicago, summed up one of the important phases of the housekeeper's rôle as "public relations counsel" for the hospital she serves.

"Patients are our best press agents," Mrs. McCully continued, "and they like to talk about their hospital experiences and the services they were accorded. So, aside from the fact that cleanliness is necessary, it behooves the housekeeper to see that an atmosphere of harmony, cleanliness and service well rendered is maintained at all times."

•

Continuing the discussion of public relations aspects of the housekeeper's work, Ruth Shelburne, assistant housekeeper at Wesley, asserted that "the housekeeper is an invisible hostess. As such, it is her duty to see that patients are handled as tactfully as possible and that their demands are dealt with as promptly as possible and with good-natured cooperation."

•

Technics Discussed

Specific housekeeping technics, including maintenance, selection of blankets, safety practices and asepsis, occupied the attention of the housekeepers at the early afternoon session on Thursday. Marie Neher, housekeeper of the University of Chicago Clinics, described methods of maintaining various types of floors, including rubber tile, mastic tile and wood, and explained the wall washing and general housecleaning procedures that are followed at the clinics.

Following Miss Neher, Mrs. Mildred Page, housekeeper-on-leave, Henrotin Hospital, Chicago, spoke on the selection and care of blankets.

The fact that the housekeeper has a responsibility for the safety not only of her employes but also of other staff members and of visitors to the hospital was emphasized by Olenius Olson Jr., safety engineer, St. Paul Mercury Indemnity Company, Chicago. Mr. Olson pointed out numerous ways in which the housekeeping department can cut down accidents and thereby reduce the amount of time and money that is lost by institutions each year as a result of accidents.

Mrs. Edna H. Nelson, administrator of Women's and Children's Hospital, Chicago, warned her listeners that it is just as much the housekeeper's job to wage war on bacteria and disease, enemies of health, as it is the soldier's to defeat the enemies of the nation. Hospitals must protect civilians, she asserted, and to this end all hospitals, and particularly all housekeepers, must be relentless in the prosecution of a program of asepsis and sanitation.

•

Know Both "Petunias and Paints"

Perhaps most people think of the housekeeper as having to do only with the cleanliness of the hospital, but, in reality, she must be a first-class purchasing agent also. Mrs. Alta M. LaBelle, housekeeping director of Michael Reese Hospital, Chicago, and director of the institute, warned her fellow students not to overlook or sidestep this important phase of their work. Moreover, the speaker pointed out, the housekeeper's purchasing responsibilities reach much farther than just furniture and furnishings.

"She must be familiar with petunias and paints; with shades and soaps; with buffers and sanders; with sponges and steel wool; with screws and machines; with light bulbs and scrub brushes."

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Plan Your Color

Effective decoration can't be achieved without a plan, asserted Raymond P. Sloan, editor of The MODERN HOSPITAL, in his talk on interior decoration in the hospital. Mr. Sloan pointed out that the whole hospital, rather than just one room or one department, must be considered in planning the decoration. Furthermore, he urged that the scheme of decoration be kept as simple as possible. "The truly beautiful things are the simplest," Mr. Sloan declared.

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Build Up Employe Morale

Various incentives and methods of building morale of employes, all of which are particularly important now, were described by Nellie Gorgas, administrator, St. Barnabas Hospital, Minneapolis. First she suggested that through good training programs the employes could learn to do better work and thus merit higher salaries.

The prestige of working at a good hospital can be a powerful incentive. Per-

manency of employment should be stressed to the employes so that they will appreciate this aspect of their work.

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Disagree on Division of Duties

There was considerable division of opinion on the subject of the division of housekeeping duties in hospitals, discussed at the panel round table which closed the formal sessions of the housekeepers' institute. Arguments and discussions waxed hot over such problems as "Should painters be under the housekeeping department?"; "Should the linen room be supervised by nurses?"; "Who is responsible for establishing standardized practices in housekeeping departments?"

The discussion was led by Dr. Roger DeBusk, administrator, Evanston Hospital, Evanston, Ill., with E. I. Erickson, Augustana Hospital, Chicago; Mrs. Mildred Page, Henrotin Hospital, Chicago; Orpha Daly, Berwyn Hospital, Berwyn, Ill., Mrs. Alta M. LaBelle, Michael Reese Hospital, Chicago; Edgar Blake, administrator, Wesley Hospital, Chicago, and Leland J. Mamer, engineer, Evanston Hospital, Evanston, Ill., participating.

Engineers' Question Box

Flake Ice Machines *vs.* Central Type

Question 22: Are the newer types of ice-making machines—flake ice, chip ice and cube ice—better in hospitals than the old central ice-making machines? Why?—B.J.T., Ala.

ANSWER 1: I believe the newer types of ice-making machines are better for hospitals than the central type of large machine because they are simpler to maintain, more economical to operate, save space and are more sanitary. Using the central large type machine to make block ice, it is necessary to cut the ice into small pieces for various uses; this requires considerable hand labor, which is insanitary and wasteful.—WILLIAM J. MOMBERGER, *Orange Memorial Hospital, Orange, N. J.*

ANSWER 2: Cube ice made in small quantities is satisfactory, but no method of making a large quantity of cube ice in institutions is entirely practical because it involves excess handling and labor and quick deterioration of equipment. Central bulk ice makers are not exactly economical, although they may be convenient for plants using from 1000 to 5000 pounds of ice. The cost of making ice, if all costs are considered, is almost equal to the cost of purchasing commercial block ice.

Since practically all ice used in the hospital is crushed or broken, flake ice has its merits. The cost of making flake ice is less than the cost of block ice purchased or made. Flake ice is sanitary, being made in an enclosed unit and not being handled or thrown about the floor. There is no shrinkage or loss, such as is found when putting block ice through an ice breaker.—JOHN A. DOHERTY, *Cambridge Hospital, Cambridge, Mass.*

ANSWER 3: The newer types of ice-making machines are far superior to the old central ice-making plant. The first consideration is the saving that can be shown in making a ton of ice the new way as against the old way. As much as 50 per cent saving can be shown.

A second consideration, and a very important one, is sanitary conditions that surround both methods. The old style way is very insanitary owing to all the handling of the ice before it reaches the patient or the point at which it is to be used. In the new style individual machines ice is made untouched by human hands; it can be stored sanitarily in a storage bin. From the storage bin to the point of delivery it is not touched so contamination is almost eliminated.

A third consideration is that shrinkage resulting from melting is lessened to a considerable degree. Especially is this true of flake ice, as it lies so close together that circulation of air through it is reduced to a minimum. Chip ice and cube ice have more shrinkage, but still much less than the old style cakes of ice.

A last consideration is the ease of handling and the convenience of using flake ice, chip ice or cube ice. It is uniform in size and, therefore, does not need to be broken up again, even for use in ice packs.—LELAND J. MAMER, *Evanston Hospital, Evanston, Ill.*

All of the answers to the question on ice-making last month were so good that it was difficult to pick a winner. But the judge finally decided that John H. Herzog, St. Mary's Hospital, San Francisco, should receive the $5 prize.

Since the questions already published have gotten so far ahead of the answers published, further questions will not be included this month. But your questions will be welcomed and you are especially invited to send in answers to any of the questions that have been publishd during the last six months. Address correspondence to: Engineers' Question Box, The MODERN HOSPITAL, 919 N. Michigan, Chicago.

Testing the CO_2 Line

Question 24: How can I tell when I have enough CO_2 in the refrigerating systems? How can I trace or locate a small leak in the CO_2 line?—G.A.C., Fla.

ANSWER 1: We determine the sufficiency of CO_2 in our system by the temperature of the brine. If the brine temperature increases, we increase the CO_2. A leak is readily discovered by the sound of escaping CO_2 in the valves on top of the CO_2 tank. Tightening of these fittings usually stops the leak.—WILLIAM J. MOMBERGER.

ANSWER 2: The best way to tell when you have enough CO_2 in your system is by the gauges on the high and low side. In other words, on the dial of the gauge three separate readings indicate what the condenser water temperature should be and what the brine temperature should be in relation to the number of atmospheres of pressure you are carrying on the high and low sides when the machine is in operation. Usually for ice making and refrigeration purposes, the high side is carried at from 60 to 70 atmospheres and the low side at from 20 to 22 atmospheres with a condenser water temperature of from 74 to 80° F. This will bring the brine temperature down to from 0 to 5° F., provided the machine is not overloaded.

To test for a CO_2 leak, buy a tank of gas that has been treated with peppermint (any supplier will be glad to furnish this if given notice in advance). Use this tank when next charging the machine and any leaks will show up by a strong smell of peppermint. Another, more positive way is by using a soap and water solution. Use a small brush saturated with this soap solution and apply to all parts of the machine and condensers and union joints. Any leaks will cause soap bubbles to form, which are easily seen.—LELAND J. MAMER.

Maintaining the Heating System

Question 26: What maintenance of the heating system should be followed in the off-heating season?—A.B.J., Minn.

ANSWER: The traps on all radiators should be taken apart and cleaned. The parts should be inspected and if worn should be replaced with new parts. If the traps at the bottom of the risers allow steam to escape, it returns with the condensate without doing any heating. These traps are the most important. If there is a reducing valve it should also be in good condition. The main valve that shuts off the heating system should have a good seat.—WILLIAM HEALY, *Germantown Dispensary and Hospital, Philadelphia.*

CONDUCTED BY
DOROTHY DeHART

How About PERSONNEL?

Successful adjustment in one situation may be rank failure in another, this symposium reveals

THE personnel situation as pertaining to the dietary department continues serious with little chance of relief other than from larger numbers of trained volunteers; from older men and women, who because of age or other infirmities are not qualified to enter defense work, and from other minor adjustments in the work program.

There is little in hospital kitchen work, unfortunately, to entice help from other more profitable fields. Remuneration for the most part has been recognizably low; the hours, in some instances, are incredibly long. Unquestionably, hospitals in future will be obliged to organize this department on a different basis, ensuring adequate reward and opportunity to the right kind of help. It is suggested even that apprentice systems for training cooks be adopted in this country after the war, following the European pattern.

Not the least discouraging aspect of the present situation is that no general solution seems possible—for the present anyway. Conditions change daily and what appears to be the answer today is subject to revision tomorrow. Too, the problem varies according to the location and size of the institution.

Contacts with dietitians in various parts of the country indicate that more hope is being placed on the use of volunteer assistance. If women with proper training and guidance can prove such a boon to the nursing department, why should they not be equally effective in food service? Not everyone is too enthusiastic over the results thus far, but some weakness may be attributed to poor judgment in allocating work rather than to deficiencies in the general scheme. Cleaning stoves and washing dishes, while important, do not constitute the entire job. Cafeteria counters must be attended, nourishments prepared and served and salads arranged, to say nothing of clerical work, ever a burden to the executive heads and particularly so now.

Because volunteer clerical workers can be of great help, even if not available regularly, their services should be solicited, according to the dietitian of a metropolitan hospital. Unfortunately, she goes on to explain, volunteers rarely can be depended upon for daily routine, which makes it necessary to put paid workers in such positions.

Another dietetic director, on the other hand, speaks enthusiastically of the help she is receiving from volunteers. "They have proved intelligent, capable workers, and I feel they could be used to better advantage. We have them help us set up trays, do vegetables and fruits, clerical work, help serve in the wards and cafeterias, answer telephones and fill salts and peppers. Among those working for us are Red Cross canteen workers, Junior Red Cross helpers and some girl scouts."

Speaking for a large city hospital, the dietitian states frankly that she has never had any experience with volunteers. Lack of employes who can do the heavier duties is causing her the most trouble. "Our dining room personnel assists in preparing vegetables, fruits and salads between meal periods, making volunteers for such service unnecessary."

It is generally agreed, nevertheless, that volunteers constitute one answer to the problem. Toward this end it is recommended that dietitians consult with their local Red Cross organizations explaining their needs and determining how the attention and interest of lay groups can be directed to services they may render in the dietary department.

Next comes the possibility of using older men and women. As one dietitian puts it: "Our experience with older men, particularly, has not been too satisfactory. In an institution as large as ours, there is considerable heavy work to be done and the older men too often become compensation cases owing to lifting cases of milk and eggs."

While the same opinion is shared by another dietitian, she is more optimistic about using older people, especially those who are still active in mind and body, to do cooking and light work. They may be slower in learning and are usually slower in action than a younger person, but she finds they often make up for it by maintaining a steady gait.

One hospital has experimented with placing women in positions formerly held by men in cafeterias, dining rooms and diet kitchens. The difficulty is that many of the women have been led to believe that much of the work is too heavy for them and are disposed to give up before giving it a fair trial. The dietitian is now endeavoring to overcome this by a series of talks. At the same time she is attempting to formulate a job analysis that will allocate as few positions as possible to male employes.

In another institution placing women in positions formerly held by men is regarded as one solution to the personnel problem. These include dishwashers, potwashers and cooks. And men waiters, of course, are being replaced by girls and older women.

Some dietitians are experimenting successfully with the handicapped. Much depends upon the care with which they are selected for the particular job. They can become useful employes, according to one dietitian, who speaks from actual experience,

their disabilities proving no detriment to their work. Their tasks, she goes on to explain, should be those that do not tax or require weakened or missing limbs or fingers, nor should their duties necessitate the aid of other employes who are already fully occupied with their own work. Deaf people she also includes as possibilities, particularly if they are given routine tasks that require little spoken communication with others.

Opinion differs on this, too. "We have not had much success with physically handicapped employes," another dietitian states frankly. "Some were not able to stand and do much, and walking was too much for them."

In many hospital kitchens more Negro help is being used. Although they are now being taken into defense industries, a greater quantity of them is available than of whites. They apparently work together in harmony, too. The chief problem is in getting the younger ones to report on time. As one dietitian puts it: "It seems they enjoy a rather full night life."

There remains another possibility for meeting the personnel problem, namely, that of consolidating duties, using one better trained and better paid worker to do the work of two or more, who are unskilled. Some reservations are expressed over the practicability of such a plan, although it is agreed that the subject merits study.

One dietitian is frankly enthusiastic: "One efficiently trained person should be of greater value than two or more incompetent employes and should receive ample remuneration for services rendered. Such a person gives better satisfaction and requires less supervision on the part of the overburdened dietitian."

Another is open-minded. "In our situation," she explains "we do not seem to have any two jobs that if combined could be performed by a single individual, even though that person is a well-trained, experienced, efficient worker and is given good pay. However, a careful time and motion study may reveal such a possibility."

A third dietititian speaks for all when she says: "It has always been my opinion that the personnel setup should include a number of more highly paid positions. More competent employes would be procured and they would have some incentive to prove their worth. This would be a step in the right direction at any time, possibly even more so in peace time than now, because it would elevate the place of dietary workers in the field of labor. At present, the majority of employes seek work in institutional kitchens as a last resort. We, therefore, find our departments too often employing persons who actually are unemployable."

The acuteness of the personnel problem varies according to location. In some instances lack of trained workers is causing the greatest concern. One hospital located in a small community that has no large defense plant reports no great difficulty in getting kitchen help but adds that trained people are at a premium.

"Many of our employes have been with us for more than ten years," the dietitian says. "The boys we have are of high school age, not yet old enough to be drafted. We would rather have fewer persons and have these well trained and well paid, but we find them impossible to get in this community, nor can we entice others to make their home here. Consequently, we have inexperienced help, which reduces our efficiency."

In the meanwhile there is little that the dietitian can do apparently but to study the local situation and get along from day to day as best she can. At least, she can streamline her menus and eliminate all dishes involving complicated recipes. She can also strive to make working conditions as agreeable as possible, to keep satisfied those who "stand by."

Blending *Special Diets*

MABEL STEGNER
HOME ECONOMIST, NEW YORK CITY

IN THE preparation of special diets and tube feeding, electric blenders are proving invaluable in many hospital diet kitchens. Meat, fruit or vegetables, raw or cooked, or any prescribed combination of foods can be speedily blended to a smooth, even consistency. In the process of blending, cellulose fiber is so finely subdivided that the resulting products are accepted by many doctors wherever puréed food has been specified.

In blending a single service of meat or vegetables, about 2 ounces of liquid, which may be milk, tomato juice or meat broth, is placed in the glass container of the blender. To this is added from 4 to 6 ounces of meat or a combination of meat and vegetables. Either cooked or raw meat and vegetables may be blended. The blending time, depending upon the type of food used, is from twenty seconds to three minutes. Some combinations, using raw ingredients, which have proved to be practical are as follows:

Mixed Greens

¼ cup meat stock
⅓ cup sliced green beans
3 chicory leaves
2 tablespoons sliced leeks
⅓ cup peeled sliced potatoes

Mixed Vegetables (Vegetarian)

¼ cup water
⅓ cup sliced beets
⅓ cup sliced carrots
⅓ cup sliced sweet potatoes
2 escarole leaves
2 tablespoons sliced leeks

Beef With Vegetables

½ cup tomato juice
4 oz. diced beef
½ cup diced potatoes
½ cup sliced string beans
Few sprays parsley
Few sprays celery leaves

Beef Liver and Spinach

½ cup tomato juice
4 oz. diced liver
1 cup tightly packed spinach
Few sprays parsley

Chicken and Peas

¼ cup milk
4 oz. diced chicken
½ cup shelled peas
Few sprays parsley
Few sprays celery leaves

Vegetables With Lamb

½ cup tomato juice
4 oz. diced lamb
½ cup shelled peas
¼ cup sliced carrots

Few sprays parsley
Few sprays celery leaves

Lamb Kidneys With Vegetables

¼ cup tomato juice
2 lamb kidneys (6 oz.)
¼ cup sliced carrots
¼ cup sliced potatoes
Few sprays parsley

In using any of the foregoing recipes the operation is simple. All of the ingredients are placed in the glass container of the electric blender and the cover is put on. The blender is then turned on and allowed to run until the contents are completely blended. The blended mixture is then heated in a small covered saucepot over low heat until the meat is cooked, stirring occasionally. If desired, salt and butter can be added. If liquid and other ingredients are hot when placed in the blender, it is often possible to serve them without reheating.

The electric blender can also be used in preparing adequate and varied tube feeding diets. Any combination of fruits, vegetables or of meat and vegetables can be prepared according to the doctor's prescription, depending on the type of case. For patients who need a general diet, the following combinations have been found practical:

Lamb

6 oz. (¾ cup) clear meat broth
4 oz. (1 cup) diced rare broiled lamb chop centers (no fat)
2 oz. (¼ cup) sliced cooked string beans
3 oz. (⅓ cup) diced cooked potatoes

Liver

8 oz. (1 cup) beef broth
4 oz. (1 cup) diced cooked liver
2 oz. (¼ cup) sliced cooked carrots
2 oz. (¼ cup) sliced cooked string beans
2 oz. (¼ cup) cooked rice

Oysters

6 oz. (¾ cup) tomato juice
4 oz. (½ doz.) raw oysters
4 oz. (½ cup) cooked swiss chard
Few sprays celery leaves

Sweetbreads

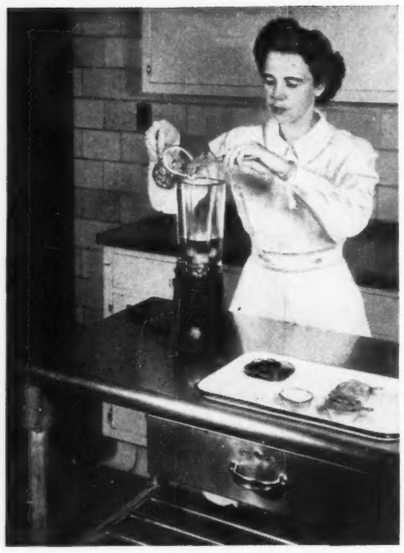
6 oz. (¾ cup) milk
4 oz. (⅔ cup) parboiled sweetbreads
2 oz. (¼ cup) sliced cooked carrots
Few sprays parsley

High Protein Feeding

6 oz. (¾ cup) milk
1 egg
2 oz. (½ cup) diced American cheese
2 oz. (½ cup) loosely packed dried beef

High Caloric Feeding

4 oz. (½ cup) thin cream
4 oz. (½ cup) ice cream



A liver and mixed vegetable tube feeding in the process of preparation in an electric blender in the diet kitchen of Welfare Hospital, New York City. Thirty-four of these electric blenders are used in this hospital under the direction of Inez Reeves, chief dietitian, for preparing beverages and special diets for approximately 1700 patients in the hospital.

3 tablespoons chocolate malted milk powder
1 egg
1 medium sized banana

In preparing the recipes for tube feeding only the tender portions of meat should be used, discarding tough membranes, and care should be taken to omit fat since it has a tendency to coagulate as it cools. In these recipes all ingredients are placed in the glass container. The blender is then turned on and run until contents are completely blended, from one to two minutes. Seasonings may be added if desired. If, in any case, the mixture is too thick to flow freely, an extra tablespoon or two of liquid can be added.

In cases in which the patient, because of oral surgery, fractured jaw or other causes, is confined to a liquid diet but is not limited as to the type of food consumed, it has been found possible to prepare quickly and easily an extremely varied diet.

For example, in a case of a multiple fractured jaw, a girl in her teens was fed through her glass tube a regular five course dinner, consisting of cantaloupe nectar, chicken bisque, lamb and vegetables, mixed green salad and strawberry ice cream.

Cantaloupe Nectar

½ cup orange juice
½ cup diced cantaloupe, ripe

Chicken Bisque

3 tablespoons evaporated milk or cream
3 tablespoons chicken broth
⅛ cup cooked chicken
⅛ teaspoon salt
Dash pepper
Spray raw celery leaves

Mixed Green Salad

2 tablespoons French dressing
½ cup tomato juice
2 large escarole leaves
¼ cup tender spinach leaves
Few sprays parsley

Strawberry Ice Cream

½ cup fresh strawberry ice cream
2 tablespoons milk

Since the importance of vitamins in the maintenance of health and as an aid in the recovery from disease has been widely recognized, many dietitians are eager to serve daily menus with an abundant vitamin content. Between-meal feedings of raw vegetable cocktails, fruit cocktails or milk smoothees, thoroughly blended, are an excellent way in which to add vitamins to the diet.

Honeydew Cocktail

⅔ cup orange juice
1 teaspoon lemon juice
1 cup diced honeydew
Dash of salt

Spinach Milk Cocktail

1 cup milk
⅓ cup tightly packed young spinach leaves

Tomato Cocktail

¼ cup water
1 medium sized diced peeled tomato
¼ cup tightly packed celery leaves
¼ cup tightly packed parsley
Dash of salt

At St. Luke's Hospital in New York City, research work, supervised by Dr. James Ralph Scott*, showed vitamin deficiencies in addition to the diagnosed disease in a large percentage of clinic and ward patients. To overcome this situation, a high vitamin cocktail was devised. The cocktail was prepared with an electric blender and served three times daily, usually after meals, to chronic and convalescent patients in medical division A. Though blended in larger quantities, the formula for a single serving is as follows:

High Vitamin Cocktail

4 oz. grapefruit juice
2 tablespoons brewer's yeast powder
5 drops haliver oil and viosterol

This cocktail can be served with ice and sweetened slightly with simple sirup to make it more palatable.

*Scott, J. R., and Janeway, M. McA.: A Nutrition Study, N. Y. State Journ. Med., March 15, 1940.

Pep Up Your Wartime Menu With

DRIED FRUITS

ILMA M. LUCAS
DIETITIAN
SAN FRANCISCO

IN THE light of present day sugar conservation, dried fruits enjoy a unique position because of their high natural sugar content. Previously, these products found warmer welcome in some European countries where they were regarded as delicacies. What a difference time or situation makes!

Because the fruit is allowed to become thoroughly ripe, fruit sugars, among other ingredients, have been allowed to develop fully. Prunes average 44 per cent sugar; apricots, 46 per cent; raisins, 63 per cent; peaches, 51 per cent, and figs 55 per cent. This sugar, commonly known as fruit sugar, not only gives a welcome lift to the sugar budget but also is readily converted into food energy.

Dried figs contain more calcium than any other fruit, fresh or dried. The preponderance of basic minerals, calcium, sodium, potassium and magnesium, makes all dried fruit potentially alkaline, a good fact to remember if battling acidity.

Certain outstanding mineral contributions must not be overlooked in these days when everyone is seeking nutritional plus values. Prunes and dried apricots are excellent sources of iron, that indispensable mineral which builds red blood. According to Whipple of the University of Rochester, both fruits compare favorably with the rich-in-iron liver or kidney, pancreas and spleen in their ability to restore red cells and hemoglobin. The fact that copper is present in both of the fruits makes this function doubly efficient.

The world today is vitamin conscious and dried fruits offer no disappointment in regard to their vitamin content. Prunes are an excellent source of vitamins A and G (riboflavin), a good source of B_1 and contain B_6 and pantothenic acid. Dried apricots are an excellent source of vitamin A, a good source of C and contain B_1 and G (riboflavin). Dried peaches are an excellent source of vitamins A and C and contain B_1 and G (riboflavin). Dried figs and raisins contain A, B_1 and G.

The laxative quality of dried fruits has long been recognized. It has been found in the case of prunes that not only is the smooth bulk of the fruit effective in producing regular elimination, but the juice, too, is equally effective.

Are dried fruits concentrated? Decidedly so; perhaps this is best indicated by the following data:

Raisins require 4 pounds fresh fruit to make 1 pound dried.

Prunes require 3 pounds fresh fruit to make 1 pound dried.

Figs require 3 pounds fresh fruit to make 1 pound dried.

Peaches require 5½ pounds fresh fruit to make 1 pound dried.

Apricots require 5½ pounds fresh fruit to make 1 pound dried.

Apples require 6 to 9 pounds fresh fruit to make 1 pound dried.

Pears require 3 pounds fresh fruit to make 1 pound dried.

The economy of dried fruit only begins here. The accompanying table gives the answer to the liberal number of servings per pound of dried fruit. The unit cost in any locality is easily determined from there on.

Newer methods of packaging have brought about newer methods of preferred cookery; dried fruit no longer requires tedious soaking. The following methods have been worked out on a time saving basis with extraordinarily good results.

RAISINS: Rinse, allow 1 cup of water for each cup of raisins, boil ten minutes, add ½ tablespoon sugar for each cup fruit.

PRUNES: Rinse, cover with water and boil forty-five minutes to one hour. No sugar is needed, but add 2 tablespoons for each cup of prunes, if desired.

APRICOTS: Rinse, cover with water and boil from thirty to forty minutes. Allow ¼ to ½ cup sugar for each cup of apricots.

PEACHES: Rinse, cover with water, boil five minutes. Lift from water and remove skins. Return peaches to water and boil thirty-five to forty-five minutes. Allow ¼ cup sugar for each cup of peaches.

FIGS: Rinse, cover with water and boil twenty to thirty minutes. Allow 1 tablespoon sugar for each cup of figs and add during last fifteen minutes' cooking.

PEARS: Rinse, remove cores, cover pears with water and boil twenty-five to thirty-five minutes. Allow ¼ cup sugar for each cup of pears.

APPLES: Remove particles of core, if any. Rinse apples, cover with water and boil forty minutes. Sugar may be omitted entirely, giving a fresh apple flavor, or allow ¼ cup sugar for each cup of fruit. The addition of a few grains of salt rounds out the flavor.

Stewed dried fruits are probably the most usual form of service. Here again it is up to the dietitian to be willing to add touches of interest, such as sliced lemon, grated orange rind, stick cinnamon and even cloves. These variables make the service more interesting. Dried fruits cooked with hot cereals or served on the prepared ready-to-eat variety give a nice balance to breakfasts.

Number of Servings per Pound

Quantity	*Weight, Cooked*	*Yield, Cooked*
1 lb. dried apricots	2 lbs. 2 oz.	10 servings of 1/3 cup fruit plus juice
1 lb. dried peaches	2 lbs. 12 oz.	11 servings of 3 peach halves plus juice
1 lb. dried figs	1 lb. 14 oz.	12 servings of 5 figs plus juice
1 lb. prunes	2 lbs. 2 oz.	11 servings of 6 prunes plus juice
1 lb. dried apples	5 lbs. 4 oz.	25 servings of 1/3 cup fruit plus juice
1 lb. dried pears	2 lbs. 8 oz.	9 servings of 3 pear halves plus juice
1 lb. raisins	2 lbs.	9 servings of 1/3 cup fruit plus juice

November Menus for the Small Hospital

Maud A. Perry

Consulting Dietitian, San Diego, Calif.

	Breakfast		Luncheon or Supper				
Day	Fruit	Main Dish	Soup	Main Dish	Potatoes or Substitute	Vegetable or Salad	Dessert
1.	Grapefruit	Boiled Eggs	Cream of Asparagus	Cold Meats	Stuffed Potatoes	Tomato Salad	Apricots
2.	Applesauce	Bacon	Tomato Juice	Chicken Giblets	Rice	Fruit Salad	Custard
3.	Oranges	Omelet	Bouillon	Lamb Chops	Potato au Gratin	Vegetable Salad	Pears
4.	Bananas	Poached Eggs	Fruit Cup	Liver and Bacon	Baked Potatoes	Pineapple and Cottage Cheese Salad	Gelatin
5.	Grapefruit	Bacon	Cream of Tomato	Cold Meats	Lyonnaise Potatoes	Carrot and Raisin Salad	Baked Apples
6.	Prunes	Scrambled Eggs	Sardine Canapes	Cheese Soufflé	Potato Puffs	Banana Salad	Peaches
7.	Oranges	Boiled Eggs	Noodle Soup	Broiled Steaks	Creamed Potatoes	Lettuce Salad	White Cherries
8.	Stewed Figs	Broiled Ham	Fruit Cocktail	Sliced Cheese	Potato Salad	Celery Hearts	Chocolate Pudding
9.	Stewed Apricots	Poached Eggs	Cream of Pea	Braised Tongue	Baked Sweet Potatoes	Tomato Salad	Berries
10.	Grapefruit	Bacon Omelet	Chicken Soup	Lamp Chops	Creamed Potatoes	Fruit Salad	Gelatin
11.	Prunes	Boiled Eggs	Vegetable Soup	Macaroni and Cheese	Stewed Tomatoes	Romaine Salad	Pineapple
12.	Oranges	Bacon	Cranberry Jelly	Chicken Croquettes	Baked Potatoes	Asparagus Salad	Figs
13.	Applesauce	Scrambled Eggs	Cream of Corn	Salmon Loaf	Rice	Vegetable Salad	Custard
14.	Stewed Figs	Broiled Ham	Fruit Cup	Cold Meats	Stuffed Potatoes	Lettuce Salad	Apricots
15.	Grapefruit	Boiled Eggs	Celery and Olives	Oyster Stew	Sweet Potatoes	Tomato Salad	Green Gage Plums
16.	Prunes	Bacon	Cream of Lima Bean	Broiled Steaks	Potato Puffs	Orange and Grapefruit Salad	Berries
17.	Oranges	Poached Eggs	Noodle Soup	Meat Loaf	Potato au Gratin	Vegetable Salad	Peaches
18.	Stewed Apricots	Ham Omelet	Bouillon	Lamb Chops	Baked Potatoes	Prune and Nut Salad	Gelatin
19.	Grapefruit	French Toast	Cream of Asparagus	Liver Fricassee	Potato Cakes	Lettuce Salad	Plums
20.	Bananas	Boiled Eggs	Fruit Cocktail	Clam Chowder	Rice Croquettes	Pear and Cottage Cheese Salad	Tapioca Cream
21.	Prunes	Bacon	Tomato Juice	Broiled Steaks	Candied Sweet Potatoes	Carrot and Raisin Salad	White Cherries
22.	Oranges	Poached Eggs	Cream of Pea	Veal Cutlet	Baked Potatoes	Tomato Salad	Baked Apples
23.	Applesauce	Broiled Ham	Vegetable Soup	Creamed Sweetbreads	Potato Puffs	Romaine Salad	Peaches
24.	Grapefruit	Omelet	Noodle Soup	Lamb Chops	Escalloped Potatoes	Fruit Salad	Blancmange
25.	Stewed Apricots	Boiled Eggs	Fruit Cup	Broiled Steaks	Lyonnaise Potatoes	Asparagus Salad	Pineapple
26.	Oranges	Bacon	Cream of Tomato	Cold Meats	Potato Salad	Celery and Olives	Baked Pears
27.	Baked Apples	Scrambled Eggs	Vegetable Soup	Macaroni and Cheese	Stuffed Tomatoes	Lettuce Salad	Berries
28.	Stewed Figs	Poached Eggs	Bouillon	Liver and Bacon	Rice	Waldorf Salad	Apricots
29.	Grapefruit	Bacon	Cream of Spinach	Chicken Salad	Sliced Tomatoes	Celery Hearts	Custard
30.	Oranges	Boiled Eggs	Alphabet Soup	Broiled Steaks	Baked Potatoes	Cooked Vegetable Salad	Cherries

Recipes will be supplied on request by The Modern Hospital, Chicago.

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RADIUM *Therapy* IS *Practical in the general hospital*

CHARLES K. P. HENRY, M.D.
MONTREAL GENERAL HOSPITAL, MONTREAL

THE problem of radium—how to use it safely—is quite different in a general hospital, even a university teaching hospital, from what it is in a hospital or institute given over entirely to the treatment of cancer. In the latter there is practically always a permanent paid staff and all the patients fall into one category, *i.e.* malignant cases, which may require surgery or radium or x-ray therapy or any combination of these. In a general hospital the care of the cancer patient is only one, and often a minor, aspect of the total care expended on those admitted to the hospital.

As its name implies, the Montreal General Hospital is not a radium institute or a cancer clinic, but it has been found possible to include a radium department and a tumor clinic among its various departments. How this was done, how these two departments operate and the results that have been obtained may prove of value and interest to similar institutions.

The mills of the gods grind slowly. It required constant effort from 1919 to July 1925 before those interested were able to obtain radium for the treatment of patients in this hospital. Even then it was owing to personal expenditure on the part of several members of the attending staff that enough radium was purchased. By the time further funds were available, a setup had been decided upon, the present method of handling radium had been adopted and the necessary regulations had been drawn up. Since April 30, 1930, the radium department has been functioning smoothly.

The Montreal General Hospital is a teaching hospital of McGill University; it has a closed staff, of which all the senior members, most of the intermediary and some of the juniors are on the teaching staff of McGill University. This applies to the two major services, medicine and surgery, as well as to all the various specialties. Since private patients are admitted to both divisions of the hospital, the medical board was faced with the problem of the control of radium therapy for all classes of patients by all members of the staff.

It was at once recognized that radium could not safely be made available for use by all the attending staff. As the other university hospitals had reciprocal private and semiprivate ward privileges with us, a prudent and tactful course had to be steered by the radium therapy committee, which had been created by the medical board and assigned all the authority needed to draw up and enforce the necessary rules and regulations. The hospital staff numbers roughly 175 and the bed distribution is as shown in table 1.

Table 1—Beds in Montreal General Hospital

Type	*Location* Cent. Div.	West. Div.	*Total*
Public	353	59	412
Semiprivate	51	6	57
Private	21	110	131
Total	425	175	600

Several members of the attending staff were qualified, by study in America, England or Europe, to use radium efficiently and safely. These formed the nucleus of those on the preferred list and provision was made for the addition of others, if, as and when they qualified. A few were allowed to use radium for certain specified lesions or systems only: for instance, two members of the dermatological department, one surgeon for breast cases only and one specialist in another department. These arrangements applied to both their public and their private cases.

The radium department was started as an independent unit, sep-

arate from the x-ray department, and it has remained so.

Radium therapy is carried out in all services in which one or more qualified attendants are available. When radium is required for any patient, public or private, a "request" card is filled out by the attendant in the radium room. This card states the amount of radium required; its form: needles, tubes, etc.; the date and hour it is needed, and where it is to be used: in the operating room or elsewhere.

The custodian, a full-time paid woman employe, delivers the radium in a proper container at the time and place requested. In both divisions of the hospital there are small safes for storing the radium before its use and when it is removed, day or night. On notification by telephone the custodian collects it, and it is then returned to the main stock, which is kept in a large safe in the radium room.

The supply of radium we have at present is shown in table 2.

All our needles have the Hopwood eye, which allows the retention suture, silk, thread or wire, to exit at the end of the needle, so that traction thereon is in direct line with the length of the needle, thus rendering its removal easy. Furthermore, in the case of wire sutures, there are no knots at the side of the needle, a factor that greatly lessens trauma.

These needles, except the 5 mgm. needles, have a filtration of 7 mm. of platinum and can safely be left in the tissues for periods up to seven or even ten days. The heavier needles, 5 mgm. each, are really small in size and have a filtration of only 0.25 mm. of monel metal. The plaques have small containers with open faces, so that squares of varying filter strength can be used with them. The tubes have appropriate brass, copper and alloy metal filters in which they fit accurately. Of course, the necessary intracervical and intrauterine rubber tubes and other applicators are in stock, as are oral, nasal, esophageal applicators.

Table 2—Radium Supply, Montreal General Hospital

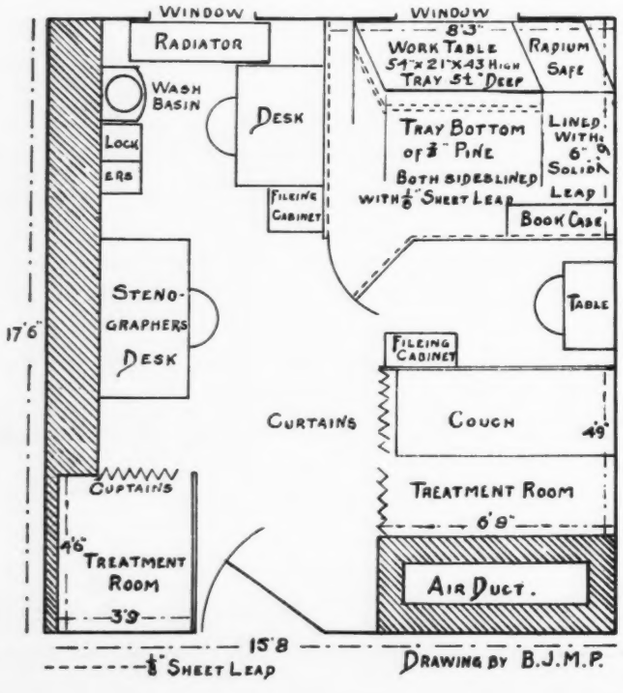
Equipment	*Number*	*Mgms.*	*Total*
Tubes.....	4	50.0	200.
	5	25.0	116.
Plaques.....	1	20.09	
	1	11.5	
	1	2.5	34.09
Needles.....	34	0.5	17.
	10	0.66	6.60
	12	1.0	12.
	57	1.5	85.5
	55	2.0	110.
	12	3.0	36.
	6	5.0	30.
Total.....			647.19

Records of all patients for whom radium is used are kept by the secretary of the department, and these are verified and checked by the attending surgeon. We now use the forms advocated by the American College of Surgeons, although we started with the forms provided by the Radium National Institute of Great Britain. When a patient returns to the tumor clinic this radium form is there and at the clinic follow-up notes are dictated to the secretary. All records in both the radium department and the tumor clinic are typewritten.

The tumor clinic, established in November 1936, is intimately connected with the radium department and has the same chief. Patients sent from it to the wards are admitted to one of the two surgical services, each of which has more than 80 public beds; more than 90 per cent of these patients come under the care of a member of the tumor clinic who is also working in one of these surgical divisions. Until it was seriously disrupted by the enlistment of many of its members in Canada's war services, the tumor clinic consisted of the following persons: chief of clinic (surgeon), assistant surgeon, clinical assistant surgeon (also member of McGill teaching staff), junior assistant surgeon (cancer research division), assistant pathologist, roentgenologist, dental surgeon (also an M.D. and on the staff of department of laryngology), secretary, three nurses, orderly and Dr. O. C. Grüner, cancer research specialist.

All patients have cytologic blood studies done by Doctor Grüner. Several hundred blood cultures have been taken by him and the James Young pleomorphic cancer virus has been obtained in 84.6 per cent of proved carcinoma cases. The value of his cytologic tests has been much appreciated and in both indoor and outdoor departments of the hospital diagnosis by this method has been sufficiently accurate to make a deep impression on the members of our hospital staff.

Patients are treated by an attendant who is qualified to use radium but who is also familiar with other forms of treatment, for example, surgery and x-ray. There is exceedingly close connection with the x-ray department, which is across the corridor from the radium room, and the director, Dr. W. Lloyd Ritchie, and his staff are in constant consultation with those who use radium, especially the chief of the latter department. The x-ray department has the following therapy units: two 200 kv. oil-cooled shockproof units and two 100 kv. shockproof units for superficial x-ray therapy; the latter



Floor plan showing arrangement of the tumor clinic. Inside walls of the radium room are lined with sheet lead to a height of eight feet.

are adapted for deep x-ray therapy at 140 kv.

These units are in the same department as the diagnostic machines, and the roentgenologist and his assistants have a permanent staff of technicians at both divisions of the hospital.

Various reports on five year treatment results have been compiled and some have been published. Others were in preparation when the war began depleting the staff. Up to date 75 medical attendants and interns have enlisted.

The hospital staff appears to be satisfied and for a year or more no request for radium privileges has been received by the committee. In all, 15 members of the staff are allowed to use radium.

The hospital was fortunate to receive a large grant for the purchase of radium from one of its governors. The interest on the unexpended balance of this fund, together with the income from radium charges, was for some years sufficient to defray the cost of the department, but lately there has been a small annual deficit.

Radon was at first purchased commercially in New York, but since the embargo on Canadian funds was enforced we have been having radon gold seeds shipped by air mail from Winnipeg, with quite satisfactory service and at a reasonable cost. The installation of a radon plant was discussed when radium was first obtained but was vetoed as costing too much. This summer a portion of our radium fund was used to purchase two mobile superficial x-ray therapy units. No radium has been purchased since 1940.

The hospital carries its own radium insurance; we have lost only three needles since operation began.

More than 2700 patients have been treated by radium, and in the head region alone, including lip, mouth, tongue and cheek, 500 patients have received some form of radium therapy. In many of these cases radium was the only form of therapy applied. In the department of gynecology, under its chief, Dr. A. D. Campbell, 425 cases of cancer of the cervix and uterus have been treated by Dr. Eleanor Percival, who did the first radium treatment in our hospital on July 2, 1926, when she treated a case of carcinoma of the cervix.

Ingenuity Creates a New Pharmacy

SIDNEY M. BERGMAN
SUPERINTENDENT, SINAI HOSPITAL OF BALTIMORE

FOR many years, the pharmaceutical work at Sinai Hospital of Baltimore was divided into two widely separated departments. A small pharmacy was located in the dispensary and catered to the needs of out-patients. The hospital pharmacy was located on the ground floor of the ward building at a point ten minutes' distant.

Neither pharmacy was convenient to an elevator that would afford vertical distribution through the plant. In order to avoid a duplication of personnel, it was necessary to transfer the crew that worked in the dispensary pharmacy to the hospital pharmacy in the afternoon, so that one place or the other was closed for part of the day. As might be expected, problems and dissatisfactions arose.

In an effort to find a solution for the situation, it was deemed desirable to locate a central pharmacy at a point at which it would be accessible to elevator service, in order to provide prompt vertical distribution of drugs and supplies, and not inaccessible to dispensary patients.

An inspection of the hospital disclosed the fact that the only area suitable for the purpose was occupied by two basement rooms close to the main elevator shaft. These apparently were not available, since one contained a huge cylindrical water tank filling three fourths of the room and a large electrically driven turbine pump. The other room, separated by a partition, contained a tangle of water and steam pipes which interfered with its usefulness.

A checking into the history of the water tank and its accessories showed that it no longer was needed for its original purpose; since that time, in fact, it never had been used and both turbine and tank were badly eroded.

A firm dealing in scrap iron purchased the tank, turbine and pipe, removed them and the proceeds from the sale were sufficient to defray the cost of refurnishing both rooms and reflooring them with cement and mastic tile.

The resulting area was divided into six rooms: (1) a compounding room with storage facilities for surgical instruments and small containers of drugs and chemicals; (2) an adjoining room suitable either for manufacturing of pharmaceuticals from crude drugs or the preparation of parenteral solutions; (3) a vault for ether and alcohol, as well as other fluids in drums; (4) a dispensary with a dispensing window facing the elevator door; (5) beyond the dispensary, a room for the storage of medical gases, and (6) leading from this room, a room containing oxygen tents, gauges, analyzers and spare parts pertaining to oxygen therapy.

By this means the pharmacist was placed in control of the dispensing of oxygen therapy equipment, medical gases, drugs, chemicals and surgical supplies. He was also enabled to manufacture the more commonly used ointments, tinctures and solutions from crude drugs and chemicals, effecting a considerable savings. Through centralization, it was possible to maintain the pharmacy crew in one place throughout the working day from 8 a.m. to 5 p.m.

The location of the pharmacy in the basement places it near the x-ray and physical therapy departments used by dispensary patients and only a few hundred feet from the old dispensary pharmacy. Since the location is at the foot of the main elevator shaft, the various supplies issued by the pharmacist can be dispatched to any floor of the hospital in the length of time required by the elevator to reach the desired floor.

The entire cost of construction and equipment did not exceed $3500. The construction work, plumbing, steam fitting, painting and the installation of fluorescent lighting were done by the maintenance department of the hospital under the supervision of the superintendent and chief engineer.

CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

For Endoscopic Procedures

General practitioners should be familiar with the indications for endoscopic procedures, says E. B. Benedict in "Endoscopy," in the March 12, 1942, issue of the *New England Medical Journal*. For peroral endoscopy, general anesthesia is rarely needed. Cocaine is the most effective local anesthetic; pontocaine is less effective, less toxic, contraindicated in asthma; larocaine is fairly effective and still less toxic.

Bronchoscopy for drainage is extremely important in bronchiectasis, especially in children, where secretions are not efficiently expelled. In children it may actually be curative. Endobronchial sulfonamide therapy may be effectively combined with bronchoscopic drainage. Bronchoscopy is valuable in the localization of lung abscess and in the early diagnosis of benign and malignant bronchial tumors. It is of doubtful therapeutic value in abscess but is useful in providing for dilatation of tuberculous strictures.

The esophagoscope is vital to diagnosis of carcinoma early enough for effective radical surgery. It has been applied also in the diagnosis and injection of varices, the diagnosis of syphilis and the study of functional disturbances. The study of benign stricture is best carried out by retrograde examination with a cystoscope through a gastrostomy opening.

The gastroscope is valuable in the diagnosis of unexplained gastric symptoms, including hemorrhage, in the differentiation of benign and malignant stomach lesions, in the differentiation of malingering and gastric neurosis from gastritis and other organic lesions (especially in the armed forces), in the diagnosis of polyposis and foreign body, in the study of the postoperative stomach. Only one fatality has occurred in 22,000 examinations by 60 gastroscopists. Study of the stomach of alcoholics has revealed great variability in susceptibility to gastritis; many do not have it. Restoration of structure in atrophic gastritis following therapy, as in pernicious anemia, has been noted. Gastritis, thought to occur in all postoperative stomachs, has been shown to be absent in 30 per cent of the cases studied. Gastroscopy may disclose some ulcers missed by x-ray. It is the surest way of observing the degree of healing. Periodic gastroscopy and x-ray study are indicated in patients with atrophic gastritis, since they are prone to develop carcinoma. In determining operability of a carcinoma, the gastroscope is important. It may also help in working out a practical classification of gastric carcinoma.

Peritoneoscopy is valuable in the differential diagnosis of abdominal tumors, liver disease and unexplained ascites and in the identification and determination of operability of abdominal carcinoma. In 37 per cent of 300 cases, exploratory laparotomy was avoided. The peritoneoscope has also been used to demonstrate, by means of repeated biopsy, the development of recurrent hepatitis into typical liver cirrhosis. A newly developed instrument for retraction of the viscera may widen the usefulness of the peritoneoscope.—Howard B. Shookhoff, M.D.

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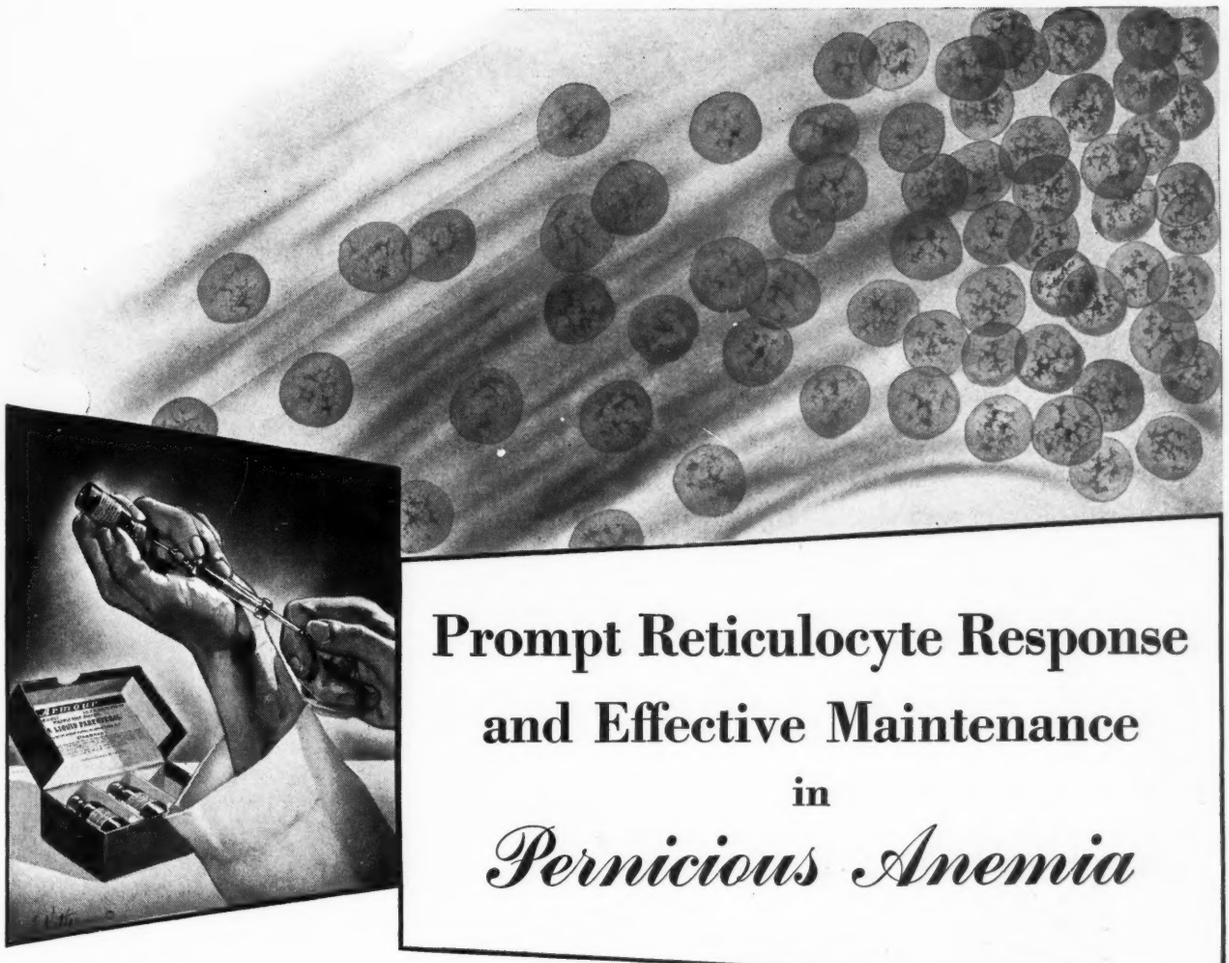
Vitamins Exposed

"The Vitamins," by Dr. Edward H. Rynearson, appearing in *The Lancet*, January 1942, is a timely article that calls attention to the large sums of money spent in this country for vitamin preparations. There follows a critical exam-



Prompt Reticulocyte Response and Effective Maintenance in *Pernicious Anemia*

That the reticulocyte response is more rapid with parenteral than with oral administration of liver preparations is now generally recognized. In addition, it has been pointed out by eminent authorities that "Parenteral injection is the most certain and convenient method for insuring adequate maintenance."[1]

But the importance of employing a reliable and potent parenteral liver preparation must not be overlooked. Thus Musser and Wintrobe have observed that "the use of inactive extracts" is one of the causes of failure in pernicious anemia therapy.[2]

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1. *Whitby, L. E. H. and Britton, C.: Disorders of the Blood, Churchill, 1935, p. 191.*
2. *Musser, J. H. and Wintrobe, M. M.: Tice, Practice of Medicine, Prior, Vol. VI, p. 852.*

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MEDICINALS OF ANIMAL ORIGIN

ination of our present knowledge of vitamins, from which it appears that most of the money spent for vitamin treatment is wasted, since only a limited number of clinical conditions have a well-established basis for such treatment. Some of the common indications for vitamin treatment, especially in vitamin B and C deficiencies, are questioned in the light of new knowledge.

The conclusion is drawn that in the present state of our knowledge treatment by vitamins has a strictly limited field of application. Whatever deficiencies exist in our present diets can be made up by proper foods. The indiscriminate purchase of vitamins at the drug store supplies no real need but represents a reaction to high pressure advertising.—Sol Biloon, M.D.

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Small Films for Mass Examinations

Various attempts have been made to photograph the fluoroscopic image direct from the fluoroscopic screen, according to Dr. M. L. Pindell in *Radiology* for February 1942. Satisfactory diagnostic results have recently been obtained with considerable saving in expense since the films used in photoroentgenography of the chest measure 4 by 5 inches instead of the conventional 14 by 17 inches. There is a proportional saving of money in the developing and storage of the films. The method is particularly adaptable for mass group examinations, as well as for follow-up rechecks.

Photoroentgenography utilizes a fast fluorescent screen which fluoresces with the most intense blue-violet light obtainable today. It is mounted in front of a light-tight box a yard long, which tapers down to receive lenses and cameras behind. At the back of the screen is mounted a lead glass plate, 2 mm. in thickness, to protect the films from x-ray fog. The lens is also a specially prepared instrument with a rating of f 1.5. It is a six element 150 mm. lens about 6 inches in diameter and is mounted near the apex in the tunnel with a screen at the opposite end so that both can be moved up and down for adjustment to the proper level for a patient standing upright. Regular x-ray film is utilized for photography.

The author used the 4 by 5 inch film to study 2107 persons from the Bureau of Indigent Relief of Los Angeles. He found that the small film closely approximates the large film in efficiency, being much better than fluoroscopy, for which Fellows reports a 13 per cent error, as compared with full-sized film and with which no permanent record is made. He does not advise the small film for private or regular hospital or sanatorium work.

The method has been advocated by others for comparison examinations in out-patient departments, in checking pneumothorax cases and in examining draftees. He believes that miniature films are destined to play an increasingly important rôle in pulmonary tuberculosis.—Eli H. Rubin, M.D.

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Looking Into the Peritoneal Cavity

Gastroscopy has arrived to stay, as an important method of gastric diagnosis. We now have, in addition, the peritoneoscope, which is coming into vogue in the best hospitals of this country and abroad, according to Dr. R. Milnes Walker and Dr. P. Lyon Playfair in *The Lancet* for Feb. 7, 1942.

The authors pay tribute to American initiative in the development of this instrument, referring particularly to the work of A. Starr and H. Frank last year, which enables us to look into the peritoneal cavity through nothing more than a puncture wound. They hold that, with experience and improvements in the instruments and technic, a greater proportion of reliable results will be obtained, giving rise to more accurate diagnoses and sparing an increasing number of patients a useless laparotomy.

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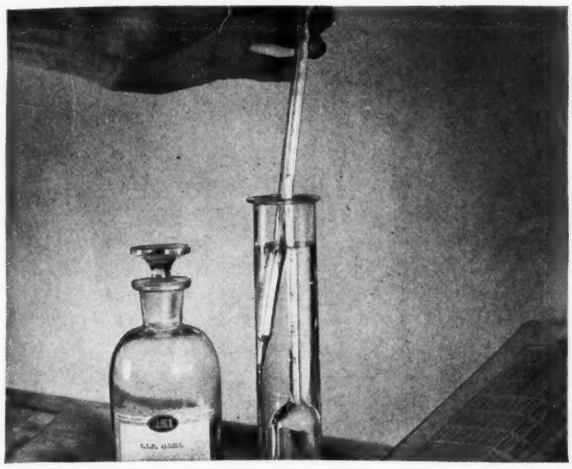

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- ☐ Massage and Sponge
- ☐ Pharmaceutical Preparations
- ☐ Pharmacy Solvent for Vegetable Drugs
- ☐ Preserving Specimens
- ☐ Protein Precipitant
- ☐ Spirit Lamps
- ☐ Stains and Reagents
- ☐ Sterilizing Instruments
- ☐ Sterilizing Skin
- ☐ Surgical Soap Preparation
- ☐ Sutures Sterile Solution
- ☐ Therapeutic Nerve Block

In cases of ascites, the operation is no more severe than paracentesis and gives far more information. In malignant neoplasms, particularly of the stomach, it helps the surgeon to determine the question of operability. In cases of carcinoma of the uterus an estimate may be made of the degree of spread. Many liver conditions can be diagnosed with certainty. Finally, in a great variety of intra-abdominal and pelvic conditions, the method helps to settle points of differential diagnosis. The authors advise the further use of this instrument in Great Britain.—E. M. Bluestone, M.D.

NOTES AND ABSTRACTS

Conducted by Carl C. Pfeiffer, M.D., F. F. Yonkman, M.D., Arnold J. Lehman, M.D., and Harold Chase, M.D.

Gramicidin

• From the Rockefeller Institute of Medical Research there has come, within the past few years, the knowledge of a new substance for attacking infections that promises to supplement the action of the sulfonamides. This new substance, or group of substances, is even more fundamental than the sulfa drugs in its approach to the problem of antisepsis. Its conception adds a new chapter to the analysis of the bacterial origin of infection.

Production

• Rene J. Dubos, experimenting in a field suggested by the great bacteriologist Pasteur, discovered that a certain aerobic, spore bearing bacillus which could be cultured from soil was capable of inhibiting the growth of gram-positive organisms in culture media. The first step, the discovery of a micro-organism which produced an enzyme capable of dissolving the capsule of type III pneumococci, led to the final culture of the bacterium with specific effect against a mixture of pneumococci, staphylococci and streptococci—representative gram-positive organisms. Upon further study Dubos found that the older cultures of this soil bacillus autolysed to liberate a soluble factor which lysed the susceptible bacteria. This aerobic spore bearing bacillus has been grown from soil, manure, cheese and from selected type cultures.

Preparation

• The soluble factor obtained from the bacterial autolysate, when separated and precipitated at pH 4.2 to 4.4 and redissolved in alcohol, is called tyrothricin. It was found to be not a simple substance but to contain two active ingredients, gramicidin and tyrocidin. Gramicidin is prepared by extracting the alcohol soluble tyrothricin with acetone and ether in which the former is more soluble. The remaining residue, soluble in acid alcohol, is tyrocidin.

In Vitro Activity

• Tyrocidin is bactericidal to both gram-positive and gram-negative species, whereas gramicidin is almost entirely limited in activity to gram-positive organisms and is only moderately effective against meningococci and gonococci. In vitro experiments showed that one milligram of tyrothricin produced lysis of 100,000,000 pneumococci at 37° C. in one hour, of staphylococci at a slower rate and of streptococci in a slightly higher concentration of tyrothricin. In addition to their lytic effect these substances are bactericidal to pneumococci, staphylococci and streptococci. For instance, one milligram of gramicidin will kill one billion

pneumococci or streptococci in two hours at 37° C. Extremely minute amounts are necessary to inhibit growth of pneumococci. Slightly larger quantities are needed to inhibit streptococci and staphylococci.

The mechanism of action of this group of substances must be fundamental to the problem of bacterial growth and control. Although it has not been finally determined, it has been shown that the dehydrogenase mechanism of susceptible organisms is inhibited. For instance, when exposed to the extract, streptococci lose their ability to reduce methylene blue in the presence of glucose. This inactivation of dehydrogenase occurs before lysis of the organisms takes place and may represent the initial mode of attack or the primary injury to the bacterial cells.

Animal Experimentation

• Mice infected with several types of pneumococci in a dosage of from 10,000 to 100,000 organisms can be protected by two milligrams of the extract. It also exerted a curative effect when administered to mice several hours after the injection of the infecting bacteria. Type specificity of the various pneumococci appeared to alter in no degree the bactericidal effects. Similar results were obtained in experimental infections with other gram-positive bacteria.

Animal experimentation showed that tyrocidin, though effective in the test tube, was relatively inactive when used in the presence of serum and in living animals.

Toxicity

• Hemolysis of red blood cells occurs with tyrothricin which hemolytic activity seems to be most potent in the tyrocidin fraction. Gramicidin requires only a low concentration but several hours' time to cause hemolysis. By using 1 per cent glucose or mannitol solution the hemolysis can be inhibited. Tyrocidin, on the other hand, causes immediate hemolysis, which is not inhibited by glucose.

Tyrocidin is considered to act like a general protoplasmic poison and, like other antiseptics, loses activity in the presence of animal tissues. Gramicidin, however, produces its effect as a specific inhibitor of certain metabolic reactions and when applied locally at the site of infection retains striking activity in vivo against gram-positive organisms. Little toxicity is evidenced when gramicidin is administered subcutaneously, intramuscularly, intrapleurally or locally on wounds or mucous membranes.

Human Applications

• Reports are appearing on the utilization of this new group of agents in the therapy of human infections. Thus far, because of their hemolytic action, the substances have been administered only in treatment of disease of the skin or of body cavities where the possibility of their entrance into the blood stream would be slight. Tyrothricin is the member most generally reported to have been tried.

The greatest efficacy has appeared to be in treating indolent ulcers of the skin, in pleurisy with effusion and in sinusitis. It has also been tried with success in otitis media, eczematoid dermatitis of the hands and feet and in bladder infections.

The suggestion has been made, supported by trial in human beings, that tyrothricin be used as a spray in the rhinopharynx of carriers of hemolytic streptococci.

Conclusion

• Only the introduction of this story of the bacillus that fights pathogenic bacteria by a chemical weapon has been written. When further reports appear from the many clinics now experimenting with this new mode of attack, we shall undoubtedly find that in this group of agents and similar substances there has been opened an entirely new and vast field of antisepsis.—HAROLD F. CHASE, M.D.

News in Review

Hospital Benefits Incorporated in New Social Security Bill; Employes Covered

A complete revision of the Social Security Act and incorporation in its provisions of hospitalization benefits and temporary disability benefits to compensate for loss of earnings during illness as well as extension of the provisions of the act to the employes of nonprofit organizations, agricultural labor, domestic servants, fishermen and self-employed are contained in House Resolution 7534 introduced by Representative Eliot of Massachusetts on September 9.

In addition to these provisions, the bill would establish a federal social insurance system, would extend the coverage of federal old age and survivors insurance, would provide benefits for workers who are permanently and totally disabled, would establish a federal system of employment offices and a federal system of unemployment compensation in place of the present system administered by the states.

In order to meet the costs of this greatly increased program, a federal social insurance trust fund is set up to be administered by the secretaries of the treasury and of labor and the chairman of the Social Security Board. Contributions are increased and equalized as between employer and employe. There is no earmarking of stated percentages of the contributions for the different types of benefits but amounts are to be allocated upon recommendation of the chairman of the Social Security Board.

The proposed new rates of contribution upon wages, salaries, commissions or other earnings up to $3000 per year per person are as shown in the table.

Persons eligible for hospitalization benefits are insured employes, their dependent wives and unmarried dependent children up to 18 years of age if unemployed. Hospital benefits go up to thirty days in any "benefit year" and, if the hospitalization benefit account permits, up to sixty days per year.

The Social Security Board is to establish a list of accredited hospitals and benefits are payable only for service in these institutions. Accredited general hospitals must provide at least bed and board, general nursing, operating and delivery rooms, ordinary medications and dressings, laboratory and x-ray services and must afford professional service, personnel and equipment adequate to promote the health and safety of individuals customarily hospitalized therein. They must also be able to make reports and certifications to the board.

Benefits are not paid for care of the tuberculous or of nervous and mental patients or for care of workmen's compensation cases. No other exclusions are mentioned in the act.

Provision is made for a national advisory hospital benefits' council, appointed by the board, to advise on standards for hospitals, studies and similar matters. The board is to be selected from "the professions and agencies concerned with the operation of hospitals and other per-

(*Continued on page* 120)

Proposed Federal Social Insurance Wage Deductions

Insured Classes	*Year*	*By Employer*	*By Employe*	*Total*
Groups Previously Insured Under Social Sec. Act	1943-45	5%	5%	10%
	1946-48	5½%	5½%	11%
	After 1948	6%	6%	12%
Self-Employed Persons	1943-45	4%		4%
	1946-48	5%		5%
	After 1948	6%		6%
Nonprofit Institutions Agricultural and Domestic Employes, etc.	1943-45	2%	2%	4%
	1946-48	2½%	2½%	5%
	After 1948	3%	3%	6%

W.P.B. Speeds Action on Maintenance Applications

WASHINGTON, D. C.—All PD-1-a applications for maintenance and repair or operating supplies and materials and equipment totaling less than $500 are no longer sent to a second reference branch.

Each such application is analyzed and given its priority rate by the first reference branch having jurisdiction over the manufacturing industry or service. After being rated by first reference branch, the application goes direct to Review and Approval whence it goes to Issuance for mailing to the applicant. This procedure cuts out one step entirely and will result in greatly accelerated action.

Hospital Benefits Included in New Social Security Bill

(*Continued from page* 118)

sons informed on the need for or provision of hospital service."

Payments will be made in cash, ordinarily to the insured worker, but provision is made for assignment to "an accredited hospital or to any other agency or institution utilized."

The road to a cooperative arrangement with Blue Cross plans is left open through the provision that the board may utilize the services and facilities of other agencies "through agreements or cooperative working arrangements with appropriate agencies of the United States or of any state or political subdivision thereof and with appropriate public agencies and private persons, agencies or institutions."

Rates of payment of not less than $3 per day and not more than $6 per day are provided but the board "may make arrangements with accredited hospitals for payment of the reasonable cost of hospital service."

The individuals covered under the act also may receive weekly cash benefits for twenty-six weeks if unemployed or absent from work because of temporary disability, these benefits varying from $5 to $23 per week depending upon the worker's previous earnings and the number of his dependents.

New Restrictions on Rubber Affect Maintenance Program

Beginning September 1 consumption of crude rubber, latex, reclaimed rubber and scrap rubber *in all civilian products* will be permitted only on specific allocations by the director general for operations. The revised order consolidates the original M-15-b and 13 amendments issued since Dec. 31, 1941.

Among the products in the various schedules for which crude rubber, latex, reclaimed and scrap rubber may be used upon authorizations issued from time to time, hospital items are well represented. These authorizations will probably be issued from month to month or from quarter to quarter after consultation with the Office of Civilian Supply.

Among products that may not be manufactured from any kind of rubber or latex are: crib sheeting, electric base plugs, plug connectors and light sockets, fan bases and blades, feeding bottle caps and covers (except nipples), flooring, tile and tiling, wainscoting (except conductive), molded wheels and casters, oxygen tent canopies, rubberized hair and fiber (except for surgical corrective appliances), stair and step treads, test tube holders, thermometer cases, typewriter keys, platens, feet and covers and vacuum cleaner tires and bumpers.

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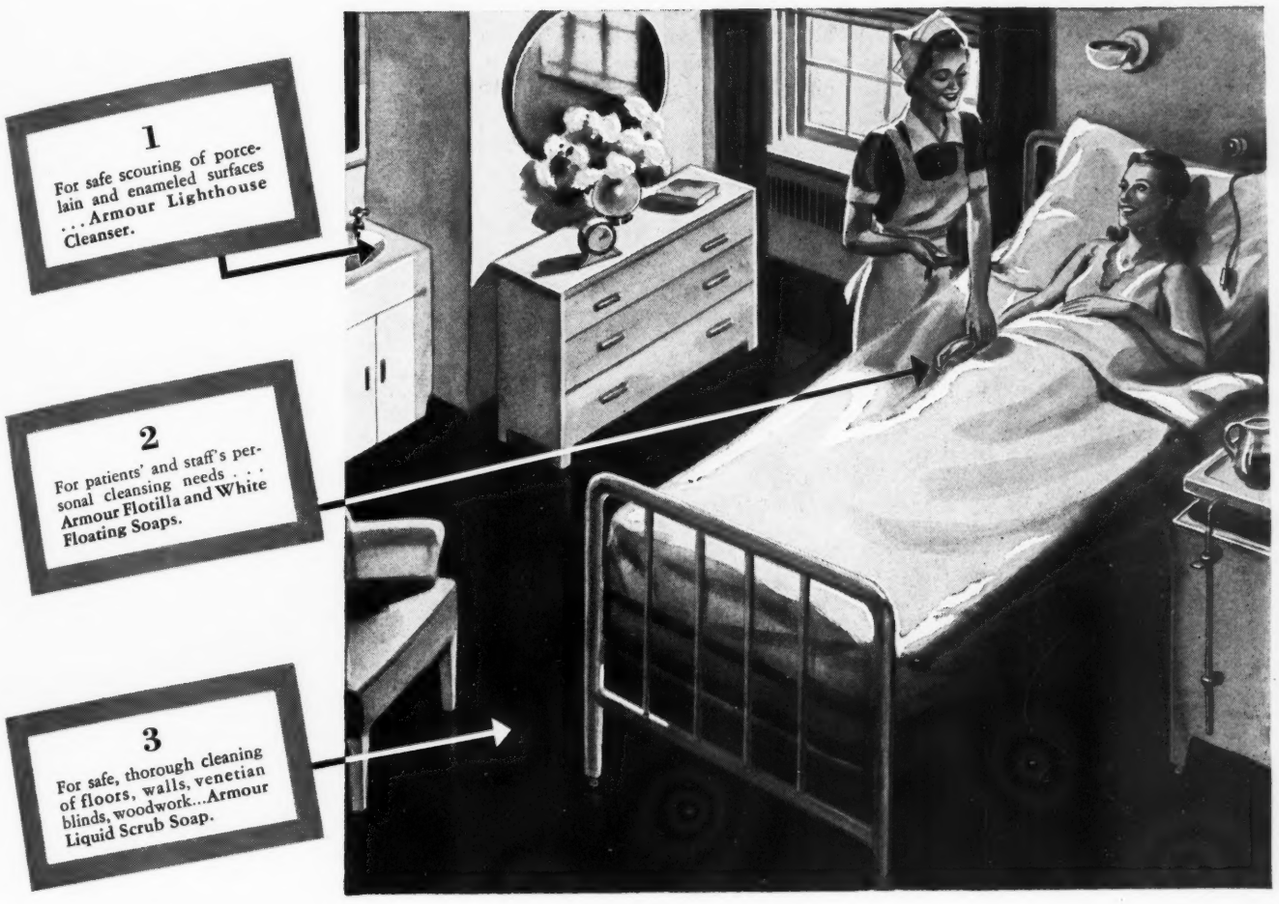

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Keep Up to Date on W.P.B. Rules Affecting Hospitals, Urges E. W. Jones

EVA ADAMS CROSS
Washington Representative, The MODERN HOSPITAL

Everett Jones, head hospital consultant of the bureau of governmental requirements, W.P.B., urges hospital officials to keep abreast of procedures necessary to obtain supplies and equipment for essential needs. Constant expansion and changes in the War Production Board make this a tedious task, but perseverance will pay well, he maintains. Useless inquiries and requests for help hamper efforts of W.P.B. in making efficient response to hospitals deserving immediate aid.

Mr. Jones suggests that each institution centralize all priority activities in one office. The priority system is always in process of readjustment in order to cope with the growing magnitude of the war effort and it is imperative that hospitals keep informed. W.P.B. has established throughout the country regional offices which furnish information and provide copies of forms and orders. These orders should be studied, their meaning and intent learned.

W.P.B. orders come mainly under four classifications, namely, general priority orders and P, M and L orders.

General priority orders cover procedures in connection with priorities, inventories, allocation classification and requirement plans.

P orders are *specific* authority to apply a preference rating by endorsement of a certification on the purchase orders issued to a supplier.

M orders are conservation orders to control the manufacture or distribution of critical metals, chemicals and other materials.

Limitation (*L*) orders are issued to prohibit deliveries of certain items except under terms provided by that order.

Purchases may be made in three different ways. The first is without preference ratings. Every attempt should be made to secure equipment and supplies without priority assistance. "Put it in heavy print," begged Mr. Jones. "Far too often a hospital takes the word of its regular supplier that some certain item cannot be delivered without a priority rating higher than A-10 signed on Order P-100. It may be true that the particular supplier cannot do so because of his inventory or backlog of orders. But the hospital should try every known source of supply before asking Washington for assistance."

The second way to purchase is with a limited blanket rating for certain classes of items. When needed supplies cannot be obtained without priority assistance, hospitals may assign an A-10 rating for repair, operation and maintenance in accordance with the provision of Order P-100. No permit is required from Washington but the terms and conditions of P-100 must be carefully followed.

The third method of purchasing is by making application to W.P.B. for a preference rating on forms provided for that purpose. Applications should be made on forms PD-1A or PD-200—*not by letter*. Form PD-1A is used to apply for items or materials in one class (except construction or expansion) when such items cannot be obtained without priority assistance. PD-200 is used to apply for a project preference rating for materials or equipment used in any expansion of facilities involving construction. PD-1A forms are not to be used to apply for any items for which preference rating has already been requested on form PD-200. Application for amendment to a rating or extension of time on project certificates should be made by letter requesting such amendment.

A limitation order applying to laboratory equipment and supplies requires

that purchase orders for such items bear a certification that they are issued in accordance with the terms of Limitation Order L-144. This order permits such certification for *research* and for expendible supplies and reagent chemicals used in instruction. Special authorization, however, is required for equipment used for laboratory *teaching*.

Order P-43 allows research laboratories to apply a preference rating of A-1-a on equipment, supplies and reagent chemicals for research, but the application for such permission to certify has to be made on forms PD-88 supplemented by form PD-107.

Washington Faces War-Time Problems of Hospital Facilities, Personnel

By EVA ADAMS CROSS
Washington Representative, The MODERN HOSPITAL

On September 1 the Federal Works Agency announced approval of a $3,207,500 hospital program for the District of Columbia and the Washington metropolitan area. The program, based on recommendations of the U. S. Public Health Service and the Vital Area Board of the District of Columbia, provides for 550 additional beds and other hospital facilities.

Action on the needs for metropolitan Washington may be indicative of what will be done in other mushrooming communities.

This grant represents a sharp reduction from an original estimated need of 1700 additional beds and it has precipitated criticism, investigations, surveys and hearings. The District committee of the Senate, headed by Senator McCarran, immediately began a study of local hospitals, available beds and other data having to do with war-time congestion of hospitals. Senator LaFollette has been giving earnest support to the drive for more hospital accommodations. Hospital beds on blueprints will do the patients no good, he says.

In view of the fact that $5,000,000 was made available for hospital expansion on July 3, it was felt in some quarters that the Federal Works Agency should release enough of these Lanham Act funds for necessary expansion in Washington. F.W.A., however, has stood firmly on the grounds that it is less a matter of funds than of maintaining a fine balance between civilian needs and the use of scarce materials. Earlier in the year the estimate of 1700 additional beds was given the District congressional committees, but since that time critical materials have been rapidly depleted and Brig. Gen. Philip B. Fleming, administrator of F.W.A., has established criteria for all public works construction.

The criterion for hospitals limits new construction in an area to four beds per thousand population in providing for deficiencies as against the previous standard of not less than four and a half beds per thousand. Though F.W.A. recognizes the inadequacy of 550 more beds in war-time Washington, it recommends that the program as approved be undertaken immediately. Later, if it is found that the population increase has been underestimated or if the criteria are too rigid for Washington, temporary facilities may be provided. The proposed conservative plans, F.W.A. officials say, will be acted on more swiftly by the War Production Board than if approval were sought for more extensive and elaborate facilities.

The new buildings will follow generally the emergency one story type, a minimum of critical materials being used. They will be of brick or clay products in line with the advice of the W.P.B. that many types of buildings, of a temporary character, can be built with brick at a small increase over the current cost of buildings erected with "critical lumber."

Hospital Wage Dispute Is Being Handled Smoothly in San Francisco

By WILLIAM G. STORIE
Vice President, San Francisco Employers Council

Smooth operation of labor relations machinery set up by the San Francisco Employers Council is resulting in a nearly friction-free handling of the current controversy between 11 San Francisco hospitals and the Hospital and Institutional Workers Union, Local No. 250.

The hospitals organized into the San Francisco Hospital Conference joined the Employers Council a few years ago for purposes of bargaining collectively with the union on an industry-wide basis.

The present controversy is entirely a wage dispute and was certified to the National War Labor Board by the secretary of labor on June 19. Three hearings have been held.

At the September 12 hearing, the Hospital Conference insisted that a check of hospital finances be made by a certified public accountant to determine ability to absorb any further wage increases.

The demands made by the union are pursuant to a contract clause which entitles them to reopen negotiations if the cost of living index for San Francisco, as published by the U. S. Bureau of Labor Statistics, increases 10 per cent above or decreases 10 per cent below the figure published for the nearest date preceding signing of the agreement in April 1941.

After a period of negotiations during which both parties became deadlocked on the wage question, the issue was referred to the War Labor Board. But through all of this there has not been so much as an hour's stoppage of work.

Prior to 1937 the hospitals in San Francisco carried on relationships with the union directly without industry-wide collective bargaining agreements. Several individual agreements were made in 1937, but it was not until April 15, 1941, that an industry-wide agreement was made between the employers and the Hospital and Institutional Workers Union. It is under that agreement that current negotiations have been carried out.

Last March the union asked for reconsideration of the wage scales and made demands for an upward adjustment of 15 cents an hour. A counter-proposal was offered by the employers through the San Francisco Employers Council, which acted as agent for the hospital conference, offering a $5 a month increase, even though it was felt that the precarious financial condition of the hospitals did not justify any increase to the employes involved. The unions rejected this offer. The hospital employers thereupon for strategic purposes withdrew the offer but subsequently renewed it during the War Labor Board hearings.

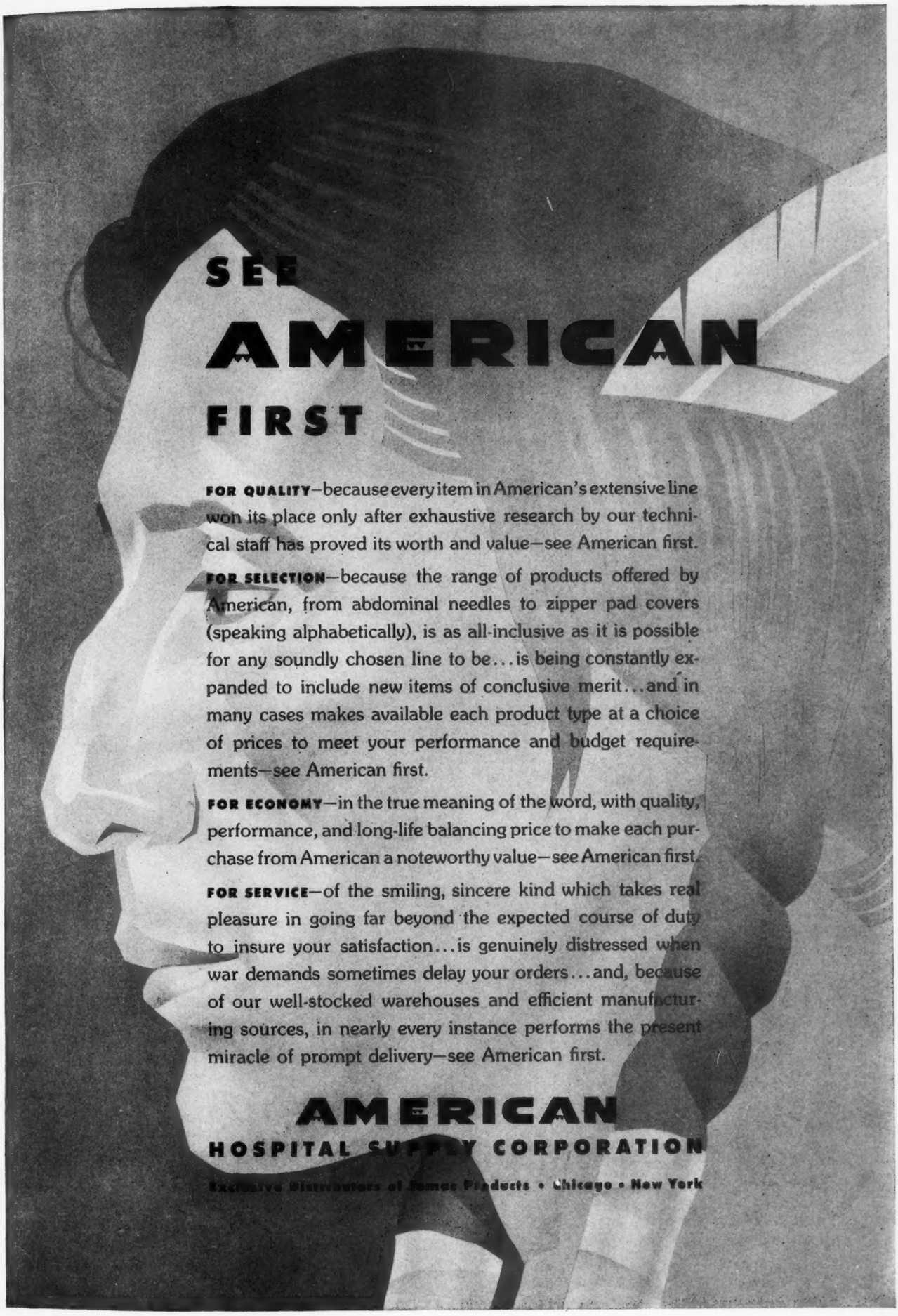
A conciliator from the U. S. Conciliation Service met with the parties involved and it was agreed the matter should be referred to the National War Labor Board through local panel procedure where the matter now rests.

Either party has the right, of course, to appeal the decision of the panel to the War Labor Board in Washington. In this controversy the position taken by the hospitals is summarized as follows:

1. They are operating at a financial loss and are financially unable to grant a wage increase.

2. They are unable to pass on to the public any wage increases.

3. The wages now being paid to employes involved in this dispute are approximately 15 per cent higher than the highest paid in any area in the United States or Canada.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4. The wages now being paid are not substandard.

The third contention above is based on the latest and most comprehensive wage comparison covering the employes working in hospitals which was published by The MODERN HOSPITAL in March and August 1941. The survey covered orderlies and ward aids, housekeeping maids and kitchen maids. The survey covered Canada and the United States by areas.

Data from the survey were included among the exhibits submitted by the San Francisco Hospital Conference in presentation of their case.

Organize Staff Units to Serve in Emergency Hospital in Interior

WASHINGTON, D. C.—The surgeon general of the U.S.P.H.S. has invited selected hospitals and medical schools in the Coastal States to organize groups of physicians who will be ready to serve when needed as supplemental staffs in emergency base hospitals to care for casualties and other patients who, in case of enemy attack, may be evacuated from hospitals in exposed cities.

Institutions invited to form units are asked to select an outstanding physician or surgeon as unit director. He will be commissioned a senior surgeon in the Public Health Reserve if he meets physical and other requirements. Male physicians may be named only if they are more than 45 years old or have physical disabilities that disqualify them for military service. The unit director will nominate the remainder of the staff and appointments will be made after clearance through the state chief of Emergency Medical Service.

Physicians in the units will be called to active duty only if hospital patients in their own regions must be moved to an emergency base hospital or if the civilian population is moved because of enemy action.

In order to avoid serious depletion of the professional staffs in the medical schools and teaching hospitals of the target areas, the surgeon general has recommended that medical schools draw their affiliated units in part from associated hospitals and that nonteaching hospitals invite physicians from other qualified hospital staffs to collaborate.

Correct Statement on Sugar Rules Governing Employes

Erroneous information regarding sugar rationing, given to the Minnesota Hospital Association and published in last month's issue of The MODERN HOSPITAL, has been corrected by the state rationing representative responsible.

The regulations on rationing applicable to hospital employes provide that "a consumer who arranges to eat 12 or more meals per week in any establishment shall surrender his book to the owner or manager of the establishment. When the book is returned to the consumer, stamps for the ration period that expired while such arrangement existed shall be detached . . . and surrendered to the board . . . for cancellation." The erroneous information stated that the employe could keep his book.

Hospitals must qualify for the larger allotment of sugar now provided by showing they are principally engaged in the care of patients acutely ill and temporary residents in the hospitals. A hospital treating chronic cases for the most part or the mentally ill is not eligible for the increased allotment.

Virginia Trains 2000 Nurses' Aides

Twenty-six hospitals in Virginia are now training more than 2000 volunteer nurses' aides. When classes have been established in the eight additional hospitals that have expressed interest in participating in the program, almost all of the hospitals in the state suitable for giving such courses will be enrolled, J. H. Wyse, Virginia O.C.D. coordinator, announced.

Your Castle Sterilizer May Now Come in a Little Black Bag

TODAY, as never before, you are urged to maintain your present equipment in first-class condition for maximum working capacity. A new sterilizer is hard to procure, and an idle sterilizer has no place in your hospital.

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CASTLE STERILIZERS

Revised PD-200 Form Speeds Hospital Applications for Building Equipment

WASHINGTON, D. C.—One of the chief sources of confusion and delay in the processing of hospital applications for new equipment was removed last month when W.P.B. issued a new PD-200 application form for project ratings where construction of any sort is involved. The new form became available on September 14 and was made mandatory on September 30.

The important difference between the new form and the old PD-200 is that the new form includes all the fixed, partially fixed and movable equipment necessary to complete the construction project and put it in operation. Under the old system only the strictly construction items could be included in a PD-200 application and all movable equipment had to be requested on separate PD-1A forms. Since the PD-1A forms were routed to various people in W.P.B., hospitals sometimes found themselves with a completed building that they could not use because of lack of vital equipment, as some of the applications might be approved and others disapproved.

There was also often considerable confusion as to whether certain specific items of equipment were "movable," especially when they were attached to the building by electric, steam, water or other connections.

All this is now eliminated. If a hospital project involves any construction, a revised PD-200 application form should be filled out and sent to the bureau of governmental requirements of the W.P.B. "Do not address it to me personally," stated Everett Jones, head hospital consultant of the schools, institutions and hospitals section of this bureau. "When addressed to me personally, the process is slowed."

Applications are studied by Mr. Jones, Dr. James Crabtree of the U. S. Public Health Service and the engineers of the project section. If approved, the list of materials requested is carefully "stripped" of all nonessentials. Then the revised list is approved as a whole.

In filling out the new PD-200 forms, a hospital should include under class No. 47900 "all other professional and scientific equipment" not included as laboratory, testing or control equipment.

The only exception to the general rule of including all equipment is office and bookkeeping machinery, which should not be included. "In fact," said Mr. Jones, "hospitals will have to go back to hand methods in their office practice for the duration if they cannot get along on what they have or can buy second hand."

For equipment that does not involve construction, either as a principal object of the project or as a requirement of installing equipment, hospitals should still use form PD-1A.

"I must reemphasize to hospitals," Mr. Jones declared, "that they should first do everything possible to fill their needs for capital equipment and maintenance and operating supplies without making any application for priority assistance. Try all the suppliers; try the second hand markets; try other hospitals; try everything that you can before applying.

"If you still can't get needed equipment, then fill out either a PD-1A or a PD-200 form and be sure to accompany it with full information."

Changes Made in Health Supplies

WASHINGTON, D. C.—The drug and pharmaceutical section of the Health Supplies Branch of W.P.B. was transferred on September 5 to the Chemicals Branch and the Toiletries and Cosmetics Branch was also included in the Chemicals Branch as a section. Then on September 19, what was left of the Health Supplies Branch was amalgamated with the Safety and Technical Equipment Branch under Francis Shields.

Largest Union Endorses Principles of Blue Cross; So Do Missouri Parties

Vigorous endorsement of Blue Cross plan principles was given in the report of the United Automobile Workers (C.I.O.) health committee, presented at seventh annual U.A.W. convention in Chicago recently.

After thorough study of various types of plans (union-owned, governmental, nonprofit and commercial), the committee declared that "the union finally chose the nonprofit group prepayment plan for its initial venture in the provision of hospital and medical services to the membership. This policy was implemented by negotiating hospitalization and surgical benefit contracts for thousands of union members in Michigan, with the union, the employers and the executives of Michigan Hospital Service and Michigan Medical Service joining in the task of launching this vast enterprise.

"The union's experience with the nonprofit plans has been generally good," continues the report. "Millions of dollars in benefits have been paid for services rendered to our people. Union members were placed on the board of Michigan Medical Service to represent the workers."

In discussing the philosophy of plans, the report states that "the basic principles of the Blue Cross hospital service plans, upon which most nonprofit medical service plans are also based, make this type of plan second only to union owned and directed cooperative hospitals and clinics. Until such time as the union is in a position realistically to contemplate construction of its own hospital and medical service institutions, the committee is actively working for the expansion and refinement of Blue Cross plans and the medical service plans which subscribe to Blue Cross principles."

The U.A.W., with 600,000 members, is the largest single union in the United States and one of the largest in the world. Its example was followed more recently by the Illinois C.I.O. conference which gave its formal approval to Blue Cross plans at a meeting in Peoria.

Endorsements of the principle of voluntary health insurance were also obtained last month in Missouri from both the Republican and Democratic state platforms.

Following the visit of C. Rufus Rorem to Puerto Rico in July, the representatives of hospitals on August 23 adopted articles of incorporation for a hospital service association and directed Felix Lamela, executive secretary of the Inter-American Hospital Association, to proceed to the United States to study Blue Cross plans.

Conserve Dealers' Stocks of Medical Supplies, Landis Urges

WASHINGTON, D. C.—Conservation by doctors and hospitals of dealers' stocks of medical and hospital supplies was strongly urged by James M. Landis, director, Office of Civilian Defense, in a statement issued last month.

"Stocks on the shelves of the dealers of this nation constitute the only reserve of medical and hospital equipment that may be available in the near future to meet civilian needs," Director Landis declared. "The hoarding and dead storage of equipment and supplies for a possible emergency should, therefore, be discouraged. Any unexpected emergency could be met by our present civilian medical and hospital resources; continued disaster could only be met by the utilization of military stores, which would be made available if there were urgent need.

"Any surplus or obsolete equipment now in the possession of physicians and hospitals ought not to be dispersed at this time," he added, "because of the difficulty of replacement and the possibility that it may be needed for the establishment of emergency base hospitals."

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Government Asks Shortened Course for Graduate Nurses to Offset Shortage

WASHINGTON, D. C.—To speed up the production of graduate nurses, the committee on educational problems in war time of the National League of Nursing Education was requested to outline by October 1 suggested curriculums for twenty-four month, twenty-eight month and thirty month periods of training.

This request was made by the subcommittee on nursing of the health and medical committee of the Office of Defense Health and Welfare following a meeting in the office of Paul V. McNutt on September 14.

For high school graduates the subcommittee on nursing recommended revising the thirty-six month curriculum so that organized education will be completed in thirty months and the last six months will be devoted to supervised practice. For students with from two to four years of approved college preparation, the subcommittee proposed compressing the training period so that the student will be graduated in from twenty-four to twenty-eight months depending upon previous education and her accomplishments in the school.

The shortage of nurses is now the most critical and acute shortage encountered in any field employing women in the war effort, according to Washington authorities. While the nursing profession has up to date carried the major responsibility for mobilizing nurses, Alma Haupt, executive secretary of the subcommittee on nursing, feels that a crucial stage has been reached requiring cooperation from other groups.

To clarify the position of nurses' aides the subcommittee on nursing recommends that a joint committee of the subcommittee and the National Nursing Council for War Service should be asked to outline a better definition of the place of these auxiliary workers. Nomenclature, qualifications, salary, training and functions are to be considered.

The Canadian federal government has made a grant of $115,000 to aid in meeting its nursing shortage.

Army Takes Over More Large Hotels for Hospital Use

WASHINGTON, D. C.—Several additional American hotels have been taken over by the Army for use as hospitals. Among these are the following on which information has been officially released: El Mirador, Palm Springs, Calif.; Don Caesar, St. Petersburg, Fla.; Nautilus, Miami Beach, Fla.; Miami-Biltmore, Miami, Fla.

El Mirador is to be a general hospital and, in addition to the hotel, 750 beds are to be provided in a cantonment type of building. The Nautilus and Miami-Biltmore are to be station hospitals.

National Park College is being taken over as an annex of Walter Reed Hospital in Washington, D. C.

In the conversion of hotels to hospitals as few changes are made as possible so that the buildings can easily be reconverted following the war.

Simple Bassinets Still Permitted

WASHINGTON, D. C.—The liberalization in Order M-126, predicted in the September issue of The MODERN HOSPITAL, was made in amendment 5 on September 4. The changes permit the continued manufacture of bassinets (limited to simple frame and basket), bed cradles, linen hampers except for frames, solution and irrigator stands, and supply and treatment cabinets for operating rooms. Moreover, the term "operating room" has been defined to mean "a room wherein it is the custom to perform surgical procedures of any character and includes sick bays or similarly designated rooms of the Army, Navy, Maritime Commission and Coast Guard."

Reference List of Official Orders

(Issued from August 15 to September 15)

Caffeine.—Order M-222, issued September 5, places caffeine and theobromine, two important medicinal drugs, under complete allocation control, beginning October 1.

Coffee.—Amendment 1, August 21, to Order M-135-c reduces the base coffee quota for wholesalers, retailers and other wholesale receivers from 75 per cent to 65 per cent effective September 1.

Construction.—Order L-41, as amended September 2, effects drastic cuts in the amount of civilian construction permissible without specific authorization from W.P.B. It became effective September 7. The L-41 order places *all* civilian construction under rigid control.

Copper.—Order M-9-c, now issued in final form, makes rigid restrictions in the use of copper even for the Army, Navy and Maritime Commission. With the exception of permitted uses named in the "military exemption list," the use of copper in the manufacture of articles listed in the order itself is prohibited even for the armed forces. Order L-161, issued August 25, effective fifteen days thereafter, prohibits use of copper or its alloys in the manufacture of parts for fuses other than current carrying parts.

Electric Fans.—Order L-176, issued September 8, places portable electric fans in the hands of manufacturers under complete allocation control.

Fire Protection Sprinkler Systems.—Order L-42, amendment 3 to Schedule 2, issued August 15, permits the manufacture of types of pipe fittings necessary for the operation of fire protection sprinkler systems and for drain pipes.

Kitchen Utensils.—Order L-30, Amendment 6, issued August 15, further reduces the use of iron and steel in the manufacture of kitchen utensils and household articles.

Laboratory Equipment.—Amendment 1, issued August 29, to Order P-43 specifically permits small research laboratories, permitted to use A-1-a preference rating, to obtain reagent chemicals.

Amendment 2 to L-144 exempts chemicals defined as "chemicals prepared and packed for reagent use in laboratories" from provisions of the order.

An amendment, September 8, to Order P-43 raised from A-2 to A-1-a the rating which certain specifically approved research laboratories may use to obtain reagent chemicals and other materials. In the case of reagent chemicals the rating can be used for both research and educational purposes, but in the case of other materials for research only.

Laundry.—Limitation Order L-91, Amendment 1, issued August 28, subjects used laundry equipment having a value in excess of $100, dry cleaning equipment and tailors' pressing machinery to the same allocation control as new and rebuilt equipment.

Lumber (Softwood).—Order M-208, issued August 22, establishes rigid control on distribution and use of all types and grades of softwood lumber. The order replaces temporary construction lumber "freeze" order, L-121.

Napthenates.—Order M-142, as amended September 5, places napthenates under complete allocation, effective October 1.

Refrigeration.—Schedule 3, issued September 3, to Order L-126 sets forth manufacturing specifications for coil or tube assemblies for refrigeration condensers or coolers. It limits the use of nonferrous metals. An amendment, September 5, to Order L-5-d, released for sale to the general public some 50,000 domestic mechanical refrigerators frozen in the hands of dealers since February 14.

Rubber.—Order M-15-b, as amended August 25, effective September 1, permits consumption of crude rubber, latex, reclaimed rubber and scrap rubber in civilian products only on specific allocations by the director general of operations, W.P.B.

Amendments, August 27, to Orders M-124 and M-174 make further restrictions on the sale, distribution and use of elastic fabric, rubber yarn and elastic thread.

Order M-15-b-1, amendment 16, issued September 1, sets specifications eliminating use of crude rubber or latex in manufacture of rubberized fabric for protective clothing.

Steel and Iron.—Amendments 5 and 6, issued September 3, to Order M-126 make changes and clarifications in the order. The order as amended liberalizes to some extent the use of iron and steel in hospital furniture (bassinets, bed cradles, linen hampers, solution and irrigator stands and supply and treatment cabinets for operating rooms).

Surgical Dressings.—Order M-134 has been amended and three schedules issued which assign a preference rating of A-2 to orders placed for fabrics suitable for manufacture into surgical dressings, industrial tape and phenolic products.

Surgical Sutures.—Order M-220, issued September 8, requires those who desire to purchase sheep intestines for surgical gut purposes to make a certification to that effect to the packer. Large meat packers were instructed to make no deliveries of sheep intestines until all purchase orders for surgical sutures are filled.

To Favor Hospitals on Cotton Textiles

A shortage in the supply of cotton textiles for use in manufacture of essential industrial and surgical products has necessitated an amendment (August 25) to Order M-134. Three schedules have been issued which assign a preference rating of A-2 to orders placed for fabrics suitable for manufacture into surgical dressings, industrial tape and phenolic products. If hospitals should have any difficulty in getting draw sheets, gowns and the like, the Textile Branch of the W.P.B. assures Everett W. Jones that it will come to their aid.

St. Barnabas Opens First Hospital Devoted Solely to the Kenny Treatment

The first hospital in the United States to be devoted exclusively to the care of victims of infantile paralysis under the Sister Kenny treatment has been opened by St. Barnabas Hospital, Minneapolis. The new institution will be known as the Sheltering Arms Hospital.

For several months, St. Barnabas Hospital has been treating a substantial number of private patients under a staff trained by Sister Kenny. However, the work has grown so extensively and Minneapolis has become such an important center for the care of "polio" patients that greatly enlarged quarters were needed to meet an insistent demand.

A special wing of the hospital is devoted to patients in the initial and contagious stages of the disease and the great sun porches and sun decks, the quiet beautiful grounds overlooking the Mississippi will be available to all.

Sheltering Arms will be operated and staffed by St. Barnabas Hospital. Heading the staff will be Dr. Wallace A. Cole, professor and head of the department of orthopedic surgery at the University of Minnesota, and Dr. Miland E. Knapp, head of the department of physiotherapy at the University of Minnesota.

The new hospital will in no way interfere with any of the proposed efforts in the future by the city of Minneapolis in caring for indigent "polio" victims. It will bear the same relationship to such a clinic as the private hospitals of the city now bear to the general hospital.

Find Used Electric Motors, Says Jones

WASHINGTON, D. C.—There are many secondhand electric motors available in the hands of dealers and manufacturing plants, says Everett W. Jones, W.P.B. hospital consultant. It may take considerable searching to find one and ingenuity to adapt it, but Mr. Jones declared they can be found. All standard new electric motors will be denied. Only after every possible means of locating the secondhand equipment have been exhausted will W.P.B. lend any assistance in finding it.

County Loses Hospital With Doctor

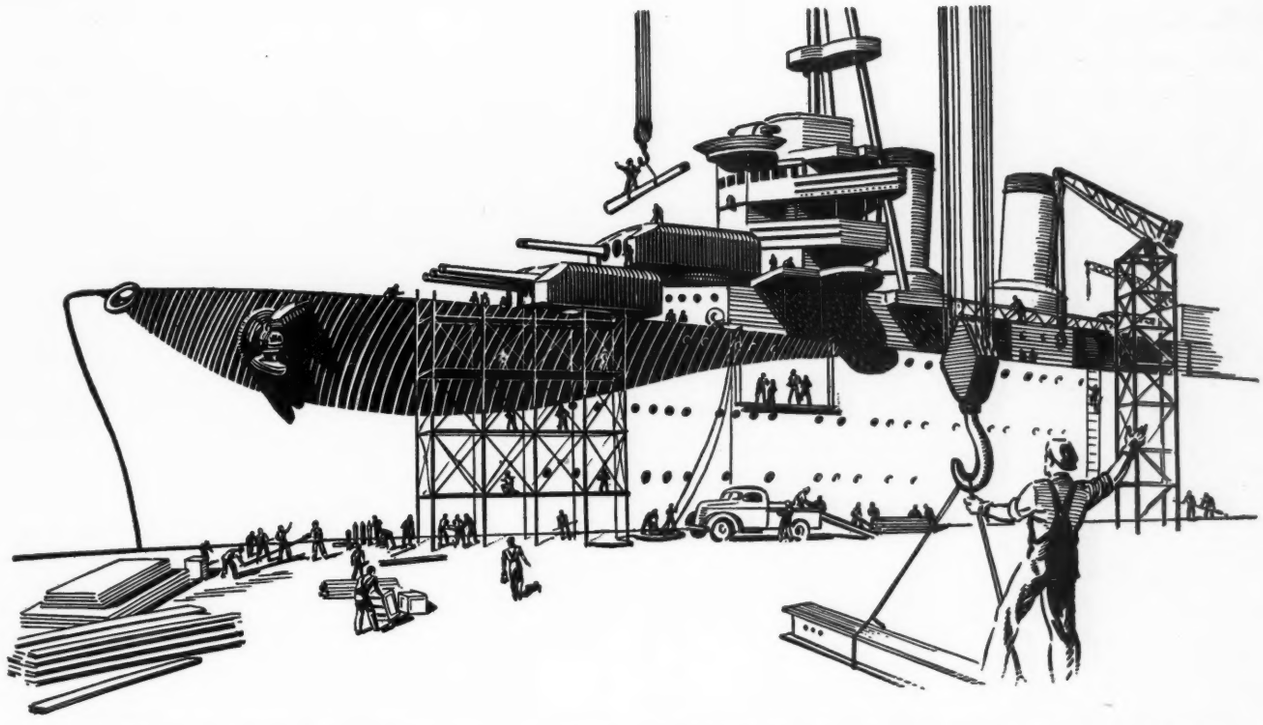
The town of Cortez and the county of Montezuma, Colorado, are without a hospital as well as a leading physician because Dr. Frank P. Girod has been called for active military duty. Mrs. Girod remained at the hospital a week following Doctor Girod's departure until the last patient could be moved to his home.

Special Protective Measures for Mentally Ill and Lepers

Among comprehensive measures to protect federal buildings throughout the nation against air raid hazards, government hospitals for the mentally ill as well as those for lepers will receive especial attention according to an announcement made on September 3 by Brig. Gen. Philip B. Fleming, Federal Works Administrator.

Some of the measures deal with the construction of splinterproof shelters; others, with roof and wall reenforcing to protect against falling debris and near-by bomb explosions. Certain measures provide for instructions as to the handling of lepers and the mentally ill in the event of enemy bombing and breached walls.

Dr. Winfred Overholser, superintendent of St. Elizabeth's Hospital, Washington, D. C., said a trained air raid force was ready to protect patients and keep them from escaping. He feels, however, that it is more a matter of protecting the patients than the public since few patients are dangerous. There are 7000 patients at the government mental hospital and some of the buildings are of material vulnerable to bombs. Practice blackouts are observed 100 per cent and patients have been drilled in following attendants to safe areas.



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An Important Problem in the Hospital, Too

In this "war of production," man-hours of working time become the very essence of victory.

In the nation's hospitals, too—already shorthanded because of the war—every step must be taken to protect the working efficiency of the personnel.

Since the common cold is the greatest single cause of disability, a program of protection against colds offers the greatest opportunity to reduce illness among hospital employes and prevent loss of working time.

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Convert 25 C.C.C. Camps Into Quarantine Hospitals for Venereal Infections

WASHINGTON, D. C.—More than 25 camps formerly used by the Civilian Conservation Corps will be made available for use as detention centers and quarantine hospitals to approximately 20 states with critical venereal disease areas, Charles P. Taft, assistant director of the Office of Defense Health and Welfare Services, announced recently.

Action to obtain these camps was taken following urgent appeals from many communities that overcrowded detention facilities were preventing adequate medical treatment of girls found infected with venereal disease. The hospitals will be operated by state health departments under standards of medical care recommended by the U.S.P.H.S.

The old Wesley Hospital in Chicago, which has been vacant since last December when the institution moved to its new home on the Chicago campus of Northwestern University, has been leased for one year with the option of renewing for the duration of the war by the Chicago Board of Health and the U. S. Public Health Service as a venereal disease hospital.

Dr. Herman N. Bundesen, president of Chicago's board of health, announced that the hospital will be an intensive treatment and research center. Two hundred bed patients can be accommodated. The hospital will serve civilians with venereal infections, particularly men deferred from the draft

Laundry Equipment Must Be Conserved

WASHINGTON, D. C.—Operators of laundry and dry cleaning plants were told on August 26 by N. G. Burleigh, chief of the Services Branch, that raw materials for production of new equipment will be impossible to obtain for the duration of the war. He pointed out, however, that if existing equipment is judiciously allocated and carefully husbanded, there will be enough to go around. To the end of judicious allocation, used laundry equipment having a value in excess of $100 has been brought under the restrictions on distribution contained in Limitation Order L-91. The order previously covered only new and rebuilt equipment.

Catholic University School Expanded

Expansion of the staff of the school of nursing education of Catholic University, Washington, D. C., has been authorized to provide intensive instruction in special classes designed to furnish administrative and nursing personnel to the armed forces, public health and the Red Cross.

Hospitals Can Be Built— in Style of 50 Years Ago

Though drastic cuts were made September 2 by the War Production Board in the amount of civilian construction through severe revisions of L-41, Everett W. Jones said hospital construction is not further affected.

"If any hospital wants to start a construction program," Mr. Jones declared, "it can build the same sort of hospital we had in 1900—two story brick with wooden floors and with the same sort of wards and pavilions. It may dampen the ardor of any hospital administrator who has ambitious building programs in mind when he realizes that he'll have to go back almost half a century in carrying out expansion plans."

Order M-208 for softwood lumber gives hospitals a fine rating on their softwood lumber for ordinary needs. Douglas fir logs have been allocated by General Preference Order M-234. All Noble fir logs and western hemlock aircraft logs were frozen in the hands of their owners on September 11 by Order M-229.

Negro Nurses Wanted

WASHINGTON, D. C.—An urgent appeal had been issued by the Army Nurse Corps for 105 colored Red Cross First Reserve Nurses.

AN OPEN WOUND IS A CULTURE MEDIUM

The laboratory worker uses serum to grow bacteria. The serum in an open lesion, whether caused by trauma, surgery or infection, also encourages bacterial growth.

In your selection of an antiseptic, therefore, it is natural to look for bactericidal activity in the presence of serum.

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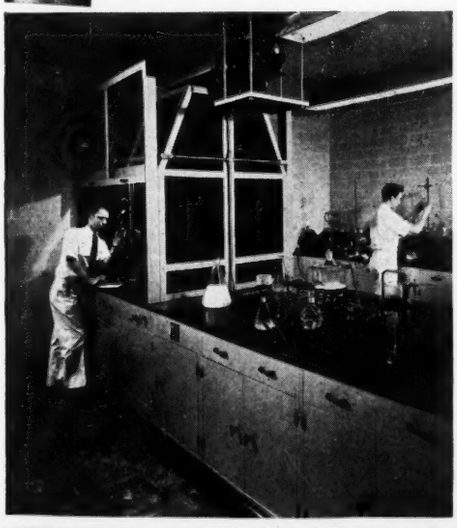

is the germicidal agent which presents high antiseptic potency in the presence of serum. Its value has been demonstrated against various types of organisms, showing a wide range of bactericidal activity.

For all routine antisepsis, including preoperative and predelivery preparation, use Furmerane in appropriate dilutions for combined effectiveness and safety.

Furmerane Solution.....1:3000—4-oz., pints and gallons
Furmerane Tincture.....1:400—4-oz., pints and gallons
Furmerane Ointment.....1:3000—¾-oz. tubes and 1-lb. jars
Furmerane Nasal Drops with Ephedrine ...1-oz., 4-oz., pints and gallons

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To Operate Ambulance Calls for Certificate of Necessity

WASHINGTON, D. C.—Ambulances and hearses, as well as virtually all trucks, buses and similar commercial vehicles, have been subjected to the control of the Office of Defense Transportation in a drastic move to attain further conservation of such equipment. The new order, which becomes effective November 15, was announced on September 9.

Certificates of necessity will be required for each vehicle and will govern the maximum mileage and minimum loads or both. No operator subject to the order will be able to obtain gasoline, tires or parts without a certificate. Applications must be submitted to the O.D.T. field offices nearest the home offices of the applicants. Tires must be checked at inspection agencies every 5000 miles or every sixty days, whichever occurs first.

Guide for Social Workers Published

An official guide for volunteers in medical social service departments has been published by the American Association of Medical Social Workers. Copies of the pamphlet are being sold for 25 cents and may be obtained by writing direct to the association in care of New York Hospital, 525 East 68th Street, New York City.

THIS IS A CHALLENGE

If you're interested in a little competitive sport, take your golf clubs along when you embark for St. Louis this month. Bait for participants includes, to date, a $25 war bond, two $5 checks for defense stamps, a $10 check, physician's bag, first-aid kit, bed tray, leather toilet kit, American flag on a chrome staff, all leather golf bag, golf clubs and a camera. In addition, Barnes Hospital is donating a loving cup, which may be retained by the golfer who wins it three years in succession.

Motion Picture Film Frozen

WASHINGTON, D. C.—The War Production Board has ordered all motion picture film in the hands of manufacturers frozen. All users of 35 mm. film will have to apply to the W.P.B. for authority to acquire unexposed film. There is no intent in this order to stop worthwhile medical or nursing educational films or hospital public relations and educational films. It is necessary only for any hospital wishing to purchase 35 mm. film to write to the bureau of governmental requirements and request permission, stating how much is wanted, where it is to be bought and the purpose of the picture to be made.

Limited Value Rating Section Abolished

WASHINGTON, D. C.—The Limited Value Rating Section of the Review and Approval Branch was abolished September 13. Effective immediately all forms PD-1A from hospitals requesting priorities assistance for materials or equipment totaling less than $500 are routed direct to the governmental requirements branch. All information necessary to determine the priority rating is obtained immediately, nor is the case sent to any other branch for concurrence or recommendation. These low value applications are processed within forty-eight hours after receipt in the branch.

Two Golden Anniversaries Celebrated

The school of nursing of St. Vincent's Hospital, New York City, combined its 1942 commencement exercises with a three day celebration of its fiftieth year of operation. Jubilee ceremonies were opened with a pontifical mass on September 17 at St. Patrick's cathedral. Educational exhibits and demonstrations of technics were conducted in the hospital's new pavilion. Milwaukee Hospital, Milwaukee, in cooperation with the Lutheran Deaconess Motherhouse, honored Rev. Herman L. Fritschel at a testimonial dinner on September 28, commemorating the fiftieth anniversary of his ordination.

Commemorating a Legend *that Became a* Legion

Eighty-eight years ago this month — October 21, 1854 — Florence Nightingale set sail for the Crimea. History and tradition were in the making that day.

The record of her accomplishments is not yet complete. Now, here at home and on every battle front, on land, at sea, in steaming jungle, parched desert and frozen waste, new, flaming chapters are being written of selfless devotion to a sacrificial cause; of service bigger than duty, bigger than life itself.

We all know and cherish the almost legendary story of Florence Nightingale. She led the way. Eighty-eight years ago she and a handful of nurses. Today, symbolizing, preserving, all that is best in a world lush with violence and hatred, pressing forward with a courage that knows no defeat, a countless legion, *her legion,* marches on.

That way lies eventual victory for mankind.

Navy Gets Nightingale Hospital

Nightingale Hospital, the new city cancer hospital now in process of construction in New York City, has been assigned to the Navy for use as a reserve hospital for the duration. Work has been at a standstill for some time because of the inability to obtain the necessary priorities.

Illinois Announces N. H. D. Awards

Illinois' National Hospital Day annual award of merit, a wall plaque, was presented to Decatur and Macon County Hospital, Decatur, Ill. Woodstock Public Hospital, Woodstock, Ill., was awarded second place and third place went to St. Joseph's Hospital, Elgin, Ill.

The A.M.A. annual convention for 1943, scheduled to be held in San Francisco, has been canceled.

Now Only 25 Kinds of Surgical Gauze

A revision of the simplified practice recommendation on surgical gauze has been approved by industry, according to an announcement of the National Bureau of Standards. The revised recommendation, which became effective from September 1, effects a reduction to 25 stock items.

Coming Meetings

Oct. 10-11—American Protestant Hospital Association, Jefferson Hotel, St. Louis.

Oct. 11-12—American College of Hospital Administrators, Jefferson Hotel, St. Louis.

Oct. 12-15—American Association of Nurse Anesthetists, Hotel Statler, St. Louis.

Oct. 12-16—American Hospital Association, Jefferson Hotel, St. Louis.

Oct. 19-22—American Dietetic Association, Hotel Statler, Detroit.

Oct. 21-24—Conference on Venereal Disease Control in War Time, auspices of U. S. Public Health Service, Arlington Hotel, Hot Springs National Park, Arkansas.

Oct. 26-31—American Public Health Association, St. Louis.

Nov. 5-6—Maryland-District of Columbia Hospital Association, Carvel Hall, Annapolis, Md.

Nov. 17-20—American College of Surgeons, Hospital Standardization Conference, Auditorium, Cleveland.

1943

Feb. 18-19—Texas Hospital Association, Texas Hotel, Fort Worth.

March 10-12—New England Hospital Assembly, Hotel Statler, Boston.

April 14-16—Hospital Association of Pennsylvania, Bellevue-Stratford Hotel, Philadelphia.

April 27-29—Ohio Hospital Association.

May 5-7—Tri-State Hospital Association, Palmer House, Chicago.

Record Librarians Cancel Session

Because, under present conditions, so few members could attend, the American Association of Medical Record Librarians has canceled its annual convention, which was scheduled to be held in Chicago, October 19 to 23. A brief business meeting for the purpose of electing new officers will be held at the Drake Hotel, Chicago, on October 20.

Nurses' Homes May Become Hospitals

As a possible solution to the war-time need for more hospital beds, the Federal Works Agency is considering plans to provide temporary dormitories for nurses in order to convert their existing quarters into emergency hospitals. A survey is now in progress to ascertain how many more hospital beds may become available under such an arrangement. Likewise, a survey is being conducted to learn what quarters may be found for the nurses.

Red Cross to Combine Campaigns

All Red Cross fund-raising activities, barring a major disaster, will be consolidated in one campaign to be conducted during March 1943, according to a recent announcement from the organization's headquarters. Under the new plan, the annual roll call usually held during November will be eliminated in favor of the combined appeal next spring.

Calls Overcrowding of Hospitals in Defense Areas "Very Serious"

Overcrowding of hospitals serving war housing projects is "very serious" in the opinion of Dr. Donald K. Freedman of the U.S.P.H.S., who is assigned as medical adviser to the Federal Public Housing Authority.

"Although 80 per cent of bed capacity is considered the maximum at which a hospital can operate efficiently, many institutions continually have occupancy rates of 100 per cent or more," Doctor Freedman states in a recent *J.A.M.A.* "Patients are cared for in hallways and, in some places, in cellars. There is simply no choice in the matter. When a hospital is crowded and patients are brought in in an emergency they must be put somewhere. Often they must be held in emergency rooms for several hours.

"An even worse situation exists with regard to delivery rooms," Doctor Freedman continues. "Almost all industrial and military communities have a high birth rate. Regulations for the protection of delivery rooms are violated frequently, also without choice. Patients are sent home after three days of postpartum care to make room for others. Many operating rooms are in use practically twenty-four hours each day, with scarcely enough time for proper cleaning. Increased numbers of highway accidents have added to the troubles of hospitals, as has the diminution of staffs.

"More than 700 requests for governmental aid in the construction of new hospitals, additions to existing hospitals or health centers have been received from approximately 500 communities. Each request has been studied by the U. S. Public Health Service, and more than 300 of the proposed projects have been recommended as justified by war-time conditions and needs."

Typewriter Rationing Order Has Been Amended by O.P.A.

WASHINGTON, D. C.—Price Administrator Leon Henderson announced on August 25 a ban on the rental of new typewriters and used nonportable machines manufactured since Jan. 1, 1935. He ordered a return by September 15 of typewriters manufactured subsequent to that date which are now on loan. To the latter order, however, a moratorium was declared on September 10 on the recall of standard sized typewriters on rental to nonmilitary agencies of the federal government. The date for return has been extended from September 15 to December 15. The moratorium does not apply to the Army, Navy and state and local governments. Their rented machines must be returned by September 15.

The order recalling rented machines does not affect lessees eligible to buy typewriters under rationing regulations. Dealers have been advised to continue these rentals upon presentation of a rationing certificate from a local rationing board or an authorization from W.P.B.

The order contained in an amendment to Revised Rationing Order No. 4 also provides for the release of certain light model portables and obsolete standard machines for unrestricted sale and places a three months' maximum rental limit on standard typewriters manufactured prior to Jan. 1, 1935, and on all used portables. The models released for sale include so-called "stripped" model portable machines lacking certain features.

The new amendment does not prohibit a dealer from renting typewriters manufactured prior to 1935 to anyone who returns a rented typewriter in accordance with the order.

Emergency Service Films Released

The organization and operation of the emergency medical services established in New York are presented in "Fighters in White," a sound motion picture produced for the state war council by the state health preparedness commission.

Names in the News

Administrators

Leon N. Hickernell has been appointed assistant director of New Haven Hospital, New Haven, Conn. Mr. Hickernell has been assistant administrator of City Hospital, Cleveland.

Dorothy H. McMasters, administrator of William Newton Memorial Hospital, Winfield, Kan., and secretary of the Kansas State Hospital Association, has been named administrator of Riverside Hospital, Paducah, Ky.

Benjamin W. Wright, former purchasing agent at Doctors Hospital, Washington, D. C., is now assistant director of the hospital. Succeeding Mr. Wright as purchasing agent is **Bruce Clark,** former paymaster and assistant purchasing agent.

Sister M. Florina recently was named administrator of St. Francis Hospital, Evanston, Ill., succeeding **Sister M. Crescentia,** who has been transferred to the western province of the Poor Sisters of St. Francis.

Howard Corlies, president and former treasurer of Fitkin Memorial Hospital, Neptune, N. J., has been named acting superintendent of the hospital during the absence of **A. W. Eckert,** who is serving in the Army medical administrative corps.

Austin J. Shoneke, who has been superintendent of New Rochelle Hospital, New Rochelle, N. Y., for fifteen years, resigned his position last month. Mr. Shoneke is succeeded by **Alex E. Norton,** his former assistant.

Samuel W. Rice, formerly superintendent of Englewood Hospital, Chicago, and more recently assistant superintendent of Miami Valley Hospital, Dayton, Ohio, has been named acting superintendent of the latter institution to serve during the absence of **Albert Scheidt,** who is serving in the medical administrative corps of the U. S. Army.

Mrs. Rachel M. Israel, for twenty-two years superintendent of the Solomon and Betty Loeb Memorial Home, East View, N. Y., has resigned from that post.

Dr. F. E. Carrington has assumed the direction of Minneapolis General Hospital in the absence of **Dr. D. W. Pollard,** who is in active service with the armed forces.

Dr. C. C. Ault has been named superintendent of State Hospital No. 1 at Fulton, Mo., succeeding **Ira A. Jones,** who went on September 1 to State Hospital No. 4 at Farmington to take over Doctor Ault's post as assistant superintendent.

J. O. Wilburn is the new superintendent of Albert Pike Hospital, McAlester, Okla., succeeding **R. H. Amrein,** temporary superintendent. Mr. Wilburn has been manager of the hospital at Okemah, Okla., for four years.

James S. North has asked to be relieved of his duties as superintendent of New Britain General Hospital, New Britain, Conn., a post he has held for seven years, and **Dr. John C. White** has been appointed managing director. Doctor White has been a practicing physician in New Britain.

Chauncey Leake, professor of pharmacology at the University of California Medical School, San Francisco, has been appointed executive vice president and dean of the University of Texas Medical Branch in Galveston. In his joint capacity, Mr. Leake will also direct the John Sealy Hospital and the College of Nursing at Galveston, Tex.

Dr. R. H. Long, assistant superintendent of State Hospital, Morganton, N. C., resigned August 1.

Margaret L. Greener, R.N., is the new superintendent of nurses at Coney Island Hospital, Brooklyn.

Here's a Floating Soap With 3 Important Advantages... Made Specially for Hospital Use!

PURITY...MILDNESS...ECONOMY... ARE THREE "MUSTS" IN A SOAP FOR PATIENT CARE. COLGATE'S FLOATING GIVES YOU ALL THREE!

Hospital requirements were given first consideration in the development of Colgate's Floating Soap. That's why it's so ideally suited to general patient care.

Nurses and patients agree that Colgate's Floating Soap is unsurpassed for purity and mildness. At the same time, hospital superintendents find that its cost puts no strain on even the most modest budget!

Let us confirm that last statement by giving you the prices on the sizes and quantities you need. And, ask for a free copy of our handy "Soap Buying Guide." Just call in your local Colgate-Palmolive-Peet representative, or write to us direct. No obligation, of course!

• For use in private pavilions, and particularly for your women patients, we recommend Cashmere Bouquet. A fine, white, hard-milled soap, it is famous for its rich, creamy lather... its delicate, lingering perfume! Available in miniature sizes.

• Palmolive is becoming increasingly popular among hospitals, both for staff use and for patient care. America's favorite toilet soap, it meets the highest hospital standards in purity. Palmolive, too, is available in miniature sizes.

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INDUSTRIAL DEPARTMENT, JERSEY CITY, N. J.

Jessie Woodfin is the new superintendent of Drummond Frasier Hospital, Sylacauga, Ala.

Jennie Sullivan has recently been named head of Bound Brook Hospital, Bound Brook, N. J.

Sara J. Clark, superintendent of Annie M. Warner County Hospital, Gettysburg, Pa., resigned recently. No successor has been named.

Miscellaneous

June A. Ramsey, former director of nursing at Harper Hospital, Detroit, has been named executive secretary of the Illinois State Nurses' Association, filling the vacancy left by the death of **Charlotte F. Landt.**

Gordon Davis, former science writer for the *Cleveland Press,* Cleveland, will head the new public relations department of Michigan Hospital Service, **John R. Mannix,** director, announces.

Col. Sam F. Seeley, executive director of Procurement and Assignment Service, has been recalled by the Army for active military duty.

Department Heads

Dr. Istvan A. Gaspar, after fifteen years' service as pathologist at Rochester General Hospital, Rochester, N. Y., has resigned to accept a similar position at Norfolk General Hospital, Norfolk, Va.

Honor Roll

Hospital administrators and assistant administrators serving in the armed forces:

U. S. Army

George F. Carter, Welborn-Walker Hospital, Evansville, Ind.

A. W. Eckert, Fitkin Memorial Hospital, Neptune, N. J.

Floyd G. Fowler, White Cross Hospital, Columbus, Ohio.

Roy D. Halloran, M.D., Metropolitan Hospital, Waltham, Mass.

Fred Heffinger, Manhattan Eye, Ear and Throat Hospital, New York City.

Thomas J. Hunston, Cleveland City Hospital, Cleveland.

J. Lincoln MacFarland, Reading Hospital, Reading, Pa.

Herman J. Nimitz, M.D., Hamilton County Tuberculosis Sanatorium, Cincinnati.

D. W. Pollard, M.D., Minneapolis General Hospital, Minneapolis.

U. S. Navy

Paul O. Hirth, M.D., Children's Hospital, Columbus, Ohio.

Dorothy Milavetz recently resigned her position as chief dietitian at Grace Hospital, New Haven, Conn., after twelve years of service. **Amy Conwell,** formerly dietitian at the Children's Community Center in New Haven, succeeds Miss Milavetz as head of the dietary department.

Helen Mae Bryan, formerly dietitian at Henrotin Hospital, Chicago, recently resigned her position to go into government work. **Beatrice Beall** comes from Grace Hospital, New Haven, Conn., to succeed Miss Bryan.

Deaths

Beatrice M. Bamber, administrative assistant to the medical director of Grasslands Hospital, Valhalla, N. Y., up to her retirement in 1940, died at the age of 67, after an active career in nursing education. In addition to her hospital duties, Miss Bamber had served as president of the New York State League of Nursing Education and secretary of the New York State Nurses' Association. She was also secretary and president of the Westchester Hospital Association.

Dr. Julius F. Wenn, retired medical director of Sacred Heart Sanitarium, Milwaukee, died in the sanitarium on September 4. Before becoming associated with the Milwaukee hospital, Doctor Wenn was superintendent of the state hospital at Kankakee, Ill.

John W. Appel Jr., president of the White Plains Hospital, White Plains, N. Y., died recently at the age of 55.

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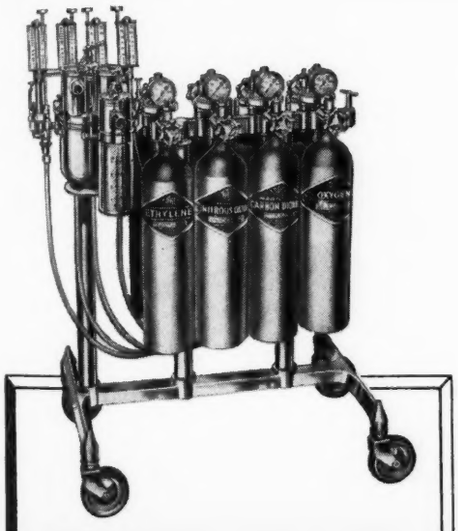

THE HEIDBRINK KINET-O-METER
is the kind of apparatus that belongs in every well-equipped hospital. However, winning the war comes first with all of us, so we suggest that for the duration, you keep your present equipment in top-notch condition. Have the Ohio Service man check your anesthesia and therapy equipment the next time he calls.

That few accidents occur in well-regulated, well-equipped hospitals is the result of excellent programs of accident prevention.

For many years we have maintained—and kept up to date—a library of Reprinted Articles on Safe Procedures in the handling of anesthetic gases, and other data published by hospitals and by the medical profession. Through the experience, training, and knowledge of the safeguards used by others, you can increase the effectiveness of your own accident-prevention program.

Material from our library will be furnished on request. Send for our library list.

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Books on Review

HISTORY OF THE SCHOOL OF NURSING OF THE PRESBYTERIAN HOSPITAL, NEW YORK. 1892-1942. *By Eleanor Lee. New York: G. P. Putnam's Sons,* 1942. *Pp.* 280. $3.50.

It is an unusual experience to find a volume so specific in its theme and, at the same time, so important to the sum total of nursing literature. The author has not only prepared the account of development of an outstanding school of nursing in this country but has also made vivid in the minds of readers the abilities and personalities of the women who have guided its fortune and the influence of concomitant world events on each period of its progress. The care with which the author has assembled her data is worthy of appreciative notice.

The account of nursing in the Spanish-American War is particularly contributive. Little is known to the present generation of what took place in this struggle that first called modern nursing to the colors; still less has appeared in the books of nursing history. Now that the skill, ingenuousness and endurance of nursing are again being put to the test it is well for every nurse to compare and to marvel at its increasing accomplishments in past wars and in the present conflict.

The stirring acquaintanceship the reader gains with the work and personality of Caroline Maxwell is the outstanding feature of the book, for Miss Maxwell *was* her school.

This book is a "must" for every reference library in a school of nursing and, without a doubt, it will find its way into the personal collections of many nurses interested in the story of present day nursing and nursing education.—DOROTHY ROGERS WILLIAMS, R.N.

NATIONAL FORMULARY, SEVENTH EDITION. *Prepared by the Committee on National Formulary. Washington: American Pharmaceutical Association,* 1942. *Pp.* 690.

This seventh edition of an essential reference volume for the hospital pharmacist and formulary committee of the staff is official from Nov. 1, 1942. It follows the standardized format of preceding editions and again reflects great credit on the American Pharmaceutical Association.

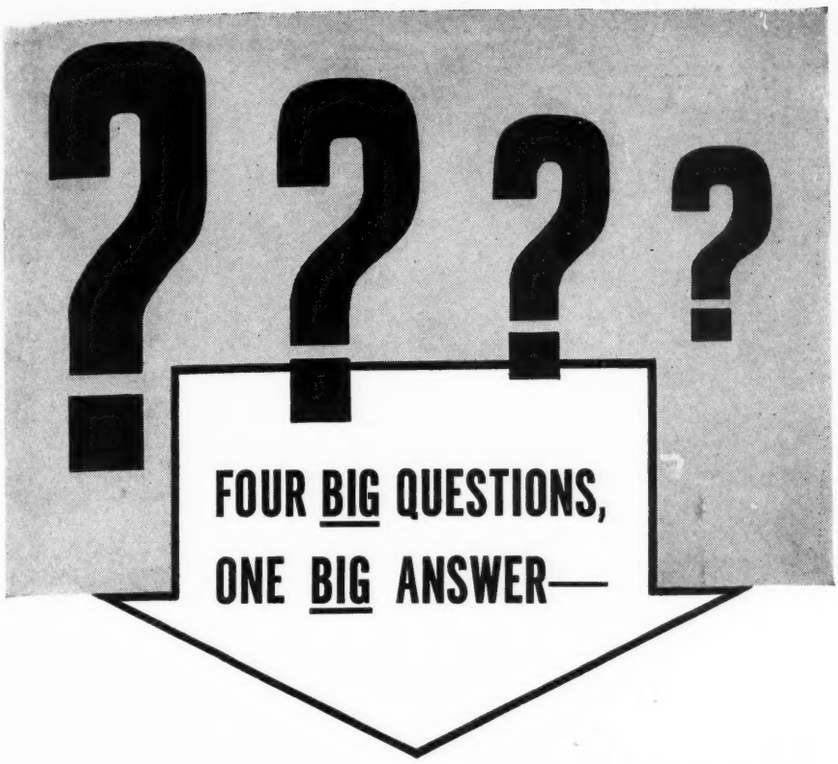
Special features of the new edition are a greatly expanded chapter on reagents and preparations for use in the clinical laboratory; a change of editorial style whereby the name of the test precedes the description of chemicals and preparations containing chemicals; an improvement in the monographs on crude drugs, and the introduction of a scientific system of color nomenclature in the crude drug monographs and in the new chapter on clinical laboratory reagents and preparations.—OTHO F. BALL, M.D.

FOOD FOR FIFTY. *By Sina Faye Fowler and Besse Brooks West. New York: John Wiley & Sons, Inc.,* 1941. *Pp.* 383. $3.

Homespun philosophy and wit are characteristic of the verse that introduces each group of recipes in this diversified book. Its theme material makes the book of invaluable use to the food director as well as to the institutional management student.

Recipes are presented in simple, clear style, with additional notes of advice or suggestion to ensure successful use.

Meals for special occasions, tea and buffet service, suggestion lists for menu planning and a creditable chapter on "Preparation and Cooking of Poultry" are other practical aspects of this useful volume.—MARY E. HINES.



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Four questions that any building manager wants to have answered in the quickest, most economical way are:

1. What's the best way to keep my floors in A-1 condition?
2. How can I clean porcelain enamel *safely* and thoroughly?
3. What cleanser will keep painted walls and ceilings looking fresh and new?
4. Can stained marble be cleaned easily?

Wyandotte Detergent is an all-around cleanser that provides a clean, clear-cut answer for any or all these questions. It is the largest selling maintenance cleaner in the world—free-rinsing, economical in use, the mainstay of building managers the country over.

For those who prefer an all-soluble cleaner, Wyandotte F-100 is available for floors and walls, particularly effective on wood, red tile, and cement. If a *paste* cleaner is preferred for porcelain enamel, use Wyandotte 97 Paste.

Your Wyandotte Service Man can supply you immediately with these products for *all* your maintenance cleaning.

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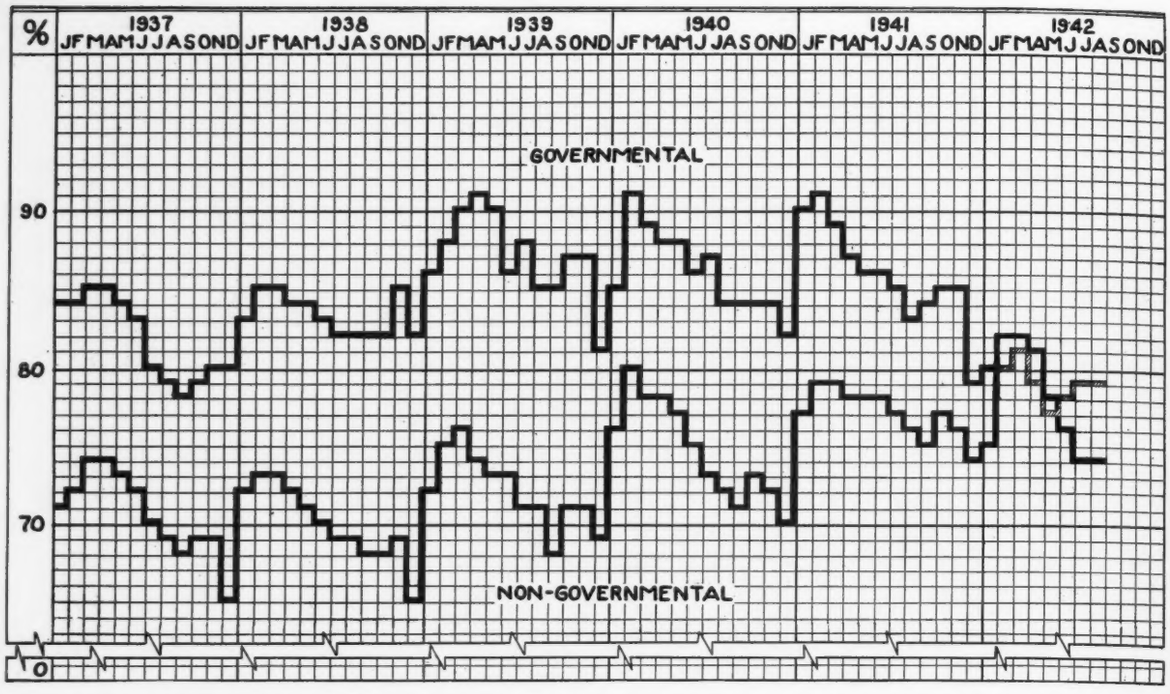
Construction Still Above 1941 Level



Voluntary hospitals were overcrowded for August while governmental general hospitals were relieved. Over 80 per cent occupancy was reported for six months or more of 1942 for voluntary hospitals in New Orleans, San Francisco, St. Paul and Cleveland.

Nineteen hospital construction projects (mostly new hospitals) were announced from August 10 to September 8, costing $5,523,000. Total new construction to date for 1942, excluding projects postponed by war, is $99,000,000 compared with $89,000,000 for the same period last year.